Sandia National Laboratories
A Department of Energy National Laboratory

CIGNA Network Point of Service (POS) Plan

Summary Plan Description

Effective: January 1, 2002

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CIGNA Network POS Plan

Effective January 1, 2002, the Lovelace Designated Provider Plan (DPP) changed its name to the CIGNA Network Point of Service (POS) Plan and incorporated the CIGNA Exclusive Provider Plan (EPP).

When you or covered family members need medical care, the POS Plan provides valuable financial protection. This booklet provides medical benefit information to help you make informed decisions when you or your covered family member use this Plan.

As alternatives to the CIGNA Network POS Plan, Sandia also offers the Sandia TOP Preferred Provider Organization (PPO) Plan, the Sandia Intermediate PPO Plan, and the Sandia Basic PPO Plan, all of which are offered to participants worldwide. The Kaiser HMO is offered to participants in certain locations within California. Employees located in Hawaii have the option of a state-sponsored Hawaii medical plan.

The CIGNA Network POS Plan is a self-insured Plan for eligible members (see Eligibility, page 7) of Sandia National Laboratories, P. O. Box 5800, Albuquerque, New Mexico, 87185 (Employer Identification Number 85-0097942), Plan 519 under the Employee Retirement Income Security Act of 1974 (ERISA) for Sandia National Laboratories. This Plan is administered on a calendar-year basis from January 1 through December 31 for accumulation of maximums, deductibles, claim filing, and filing of reports to the Department of Labor. CIGNA has assigned the following group Plan number: **3172368**. For information concerning service of legal process, contact the Sandia Legal Division, Sandia National Laboratories, P. O. Box 5800, MS 0141, Albuquerque, New Mexico, 87185.

CIGNA is the claims administrator of the Plan and is responsible for providing services, maintaining the network, maintaining member eligibility, interpreting the Plan, determining the benefits provided, administering both the in- and out-of-network appeals process, processing claims and reimbursing providers and/or members, and maintaining member services. CIGNA may delegate some or all of these services to its staff model or contracted health plans. Sandia is responsible for determining member eligibility.

This Plan will be referred to as the CIGNA Network Point of Service Plan on membership cards and in all subsequent communications.

Sandia complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), Pub. L. 104–191, that was enacted on August 21, 1996. HIPAA amended the Public Health Service Act (PHS Act), ERISA**,** and the Internal Revenue Code of 1986 to provide for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets, and group health plan coverage provided in connection with employment. The HIPAA provisions are designed to improve the availability and portability of health coverage not limited to the following:

- Limiting exclusions for preexisting medical conditions
- Providing credit for prior health coverage and a process for transmitting certificates and other information concerning prior coverage to a new group health plan or issuer
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage or have a new dependent
- Prohibiting discrimination in enrollment and premiums against employees and their dependents based on health status

This booklet is the Summary Plan Description (SPD) and is provided in accordance with the requirements of ERISA and the Internal Revenue Code. This SPD summarizes operations, benefits, claim filing procedures, and other provisions of interest.

As a member in the POS Plan, you are entitled to certain rights and protections under ERISA. This information, as well as certain general information concerning this Plan, is included as a separate booklet in your *Sandia Employee Benefits Binder* and is under the tab labeled "ERISA Information."

NOTE: The ERISA booklet is mailed separately to retirees.

Medical and other information provided to CIGNA or its staff model or contracted health plans is kept confidential and generally will be used by the Plan and its providers only for internal administration of the Plan, bona fide medical research or education, coordination of benefit provisions with other plans, subrogation of claims (including the Plan's right to reimbursement), or by CIGNA and its providers in reviewing a disputed claim.

The CIGNA Network POS Plan is maintained at the discretion of Sandia and is not intended to create a contract of employment and does not change the at-will employment relationship between you and Sandia. The Sandia Board of Directors (or designated representative) reserves the right to suspend, change, or amend any or all provisions of the CIGNA Network POS Plan, and to terminate the CIGNA Network POS Plan at any time without prior notice, subject to applicable collective bargaining agreements. If the CIGNA Network POS Plan should be terminated or changed, it will not affect your right to any benefits to which you have already become entitled.

Contents

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Highlights

Summary of Plan Changes

The following changes have been implemented since the publication of the Lovelace Designated Provider Plan (DPP) Summary Plan Description, dated January 1, 2001, and the CIGNA Exclusive Provider Plan (EPP) Summary Plan Description, dated February 1999:

- The name of the Plan has changed from the Lovelace Designated Provider Plan to the CIGNA Network Point of Service (POS) Plan.
- This Plan has replaced the CIGNA Exclusive Provider Plan.
- The location of Member Services for the Lovelace DPP has changed from Lovelace Member Services in Albuquerque to CIGNA Member Services nationwide.
- The phone number for Member Services has changed to 800-CIGNA24 (800-244-6224).
- The Lovelace Health Hotline has been replaced with the CIGNA 24-hour Health Information Line (800-CIGNA24 or 800-244-6224).
- The phone number for behavioral health services, including Employee Assistance Program (EAP) benefits, has changed to 800-335-5415.
- The service area has been expanded to cover the northern California area.
- Nonrepresented year-round students who are enrolled in a post-secondary educational program and who do not have other medical coverage are eligible to enroll.
- The provision allowing a new hire or a reclassified employee newly eligible for medical coverage to enroll in this Plan after the 31-calendar-day enrollment period has elapsed has been changed to allow enrollment only in the Sandia's Basic Preferred Provider Organization Plan (PPO) after the 31-calendar-day enrollment period has elapsed.
- The provision that allows copays under this Plan to be applied to deductibles and out-of-pocket maximums under the out-of-network Two Option Medical Plan when an employee is transferred by the company outside the service area has been eliminated.

- The Utilization Management Grievance Procedures and Appeals Procedures under the CIGNA EPP have changed.
- An independent external review process for appeals has been added.
- The following benefit changes for those members who were enrolled in the Lovelace DPP have been made:
  - Copays and/or coinsurance under the behavioral health benefits do not apply to the out-of-pocket maximum.
  - Copays under the prescription drug benefits do not apply to the out-of-pocket maximum.
  - The family out-of-pocket maximum for out of network benefits has been reduced from $9,000 to $6,000 per calendar year.
  - Routine preventive care is covered in network and out of network.
  - Sports physicals are not covered out of network.
  - Treatment for morbid obesity is subject to the same copays/coinsurance as other medical conditions.
  - Diabetic supplies are treated as any other prescription.
  - The benefit for speech, occupational, and physical therapies, and chiropractic and acupuncture services has changed from a maximum of 60 consecutive days per condition per lifetime to a maximum of 60 visits for all conditions per calendar year (combined benefit).
  - The benefit for in-network external prosthetic appliances is unlimited after the $200 annual deductible has been met.
  - There are no visit limits under the home health care benefit.
  - Infertility treatment is limited to a lifetime maximum of $20,000 and includes in-vitro fertilization, artificial insemination, GIFT and ZIFT. The office visit copay has been reduced from $20 to $10.
  - The number of inpatient days covered for mental health changed from unlimited to a maximum of 60 days per calendar year.
  - The reimbursement for out-of-network behavioral health service has been reduced from 70% to 50% of allowable charges.
  - Partial hospitalization benefits for mental health are limited to 120 days and are combined with the 60-day inpatient maximum.
  - Primary care physician (PCP) or specialist office visit increased from $5 to $10.
  - Urgent care visit increased from $10 to $25.
  - Inpatient hospital admission including behavioral health increased from $100 to $250 per admission.
  - Skilled nursing facility and/or rehabilitation hospital admission changed from $100 per admission to no copay.
  - Outpatient surgery increased from $50 to $75.
  - Generic prescription at a retail pharmacy increased from $5 to $10, and brand name prescription increased from $10 to $20.
  - Mail-order generic prescription increased from $10 to $20, and brand-name prescription increased from $25 to $40.
  - Physician house calls under the home health care benefit decreased from $5 to no copay.
  - Minor surgery in physician's office increased from $5 to $10.

- Norplant insertion will be $10 if done in the physician's office or $75 if done in an outpatient surgical facility.
- Office visit for infertility treatment decreased from $20 to $10.
- Inpatient hospice will be at no copay.
- Partial hospitalization benefits in network for behavioral health will be at a $125 copay and out of network will be 50% of allowable charges subject to the annual deductibles.
- Outpatient mental health visit increased from $5 to $10, and outpatient substance abuse decreased from $20 to $10.
- Outpatient mental health group therapy benefits increased from $5 to $10 per session.
- Mental health partial hospitalization program changed from a $10 copay per day to a $125 copay for the program.

- The following benefit changes for those members who were enrolled in the CIGNA EPP have been made:

  - Out-of-network benefits have been added.
  - Diabetic supplies are treated as any other prescription.
  - Acupuncture is a covered benefit.
  - The benefit for speech, occupational, and physical therapies, and chiropractic and acupuncture services has changed from a maximum of 60 consecutive days per condition per lifetime to a maximum of 60 visits for all conditions per calendar year (combined benefit).
  - The benefit for in-network external prosthetic appliances is unlimited after the $200 annual deductible has been met.
  - There are no visit limits under the home health care benefit.
  - Infertility treatment is limited to a lifetime maximum of $20,000 and includes in-vitro fertilization, artificial insemination, GIFT and ZIFT. The office visit copay has been reduced from $20 to $10.
  - The number of inpatient days covered for mental health changed from a maximum of 30 days per calendar year to a maximum of 60 days per calendar year.
  - The number of visits under the mental health outpatient benefits has changed from a maximum of 30 visits per calendar year to unlimited.
  - Partial hospitalization benefits for mental health are limited to 120 days and are combined with the 60-day inpatient maximum.
  - Employee Assistance Program (EAP) benefits with CIGNA providers is a covered benefit.
  - Primary care physician (PCP) or specialist office visit increased from $5 to $10.
  - Urgent care visit increased from $10 to $25.
  - Inpatient hospital admission including behavioral health increased from $100 to $250 per admission.
  - Short-term rehabilitation therapy increased from $5 to $10.
  - Skilled nursing facility and/or rehabilitation hospital admission changed from $100 per admission to no copay.
  - Outpatient surgery increased from $50 to $75.
  - Generic prescription at a retail pharmacy increased from $5 to $10, and brand name prescription increased from $10 to $20.

- Mail-order generic prescription increased from $10 to $20, and brand name prescription increased from $25 to $40.
- Physician house calls under the home health care benefit decreased from $5 to no copay.
- Minor surgery in physician's office increased from $5 to $10.
- Norplant insertion will be $10 if done in the physician's office or $75 if done in an outpatient surgical facility.
- Office visit for infertility treatment decreased from $20 to $10.
- Inpatient hospice will be at no copay.
- Outpatient behavioral health visit decreased from $20 to $10.
- Outpatient behavioral health group therapy benefits decreased from $20 to $10 per session.
- Inpatient hospital admission for behavioral health changed from a $50 per day copay to a one-time $250 copay.
- Partial hospitalization benefits in network for behavioral health changed from a $125 copay per day to a $125 copay per program.

- Monthly premium-share amounts have changed.
- Election change events allowing mid-year election change events have been removed and placed in the Pre-Tax Premium Plan booklet.
- Continuation of coverage provisions while on a Leave of Absence to the military have changed.
- Appendix A from the Lovelace DPP SPD and Appendix B from the CIGNA EPP SPD (Costs for Coverage) have been eliminated (Refer to Eligibility page 7).
- Appendix B from the Lovelace DPP SPD and Appendix D from the CIGNA EPP SPD (Member Rights and Responsibilities) have been revised.
- Appendix C (Pre-Tax Premium Plan) from the CIGNA EPP SPD has been eliminated.
- Appendix D from the Lovelace DPP SPD and Appendix E from the CIGNA EPP SPD (Commonly Asked Questions) have been eliminated.

How the POS Plan Works for You

As a member of the POS Plan, you can choose to use in- or out-of-network services each time you have a health care need.

To receive in-network benefits, your primary care physician (PCP) coordinates your care and initiates any referrals, prior authorizations, or preadmission certifications that may be required. There are no deductibles for most services, no claim forms to file, and you pay $10 for most visits. Preventive care—such as regular checkups, prenatal care, well-baby care, and immunizations—is covered.

The in-network benefit has a $1,500 annual individual out-of-pocket maximum and a $3,000 annual family out-of-pocket maximum. The in-network benefit gives you the highest benefit level through copayments and managed care. See Plan Benefits, page 25 and Accessing Care, page 45 for more information.

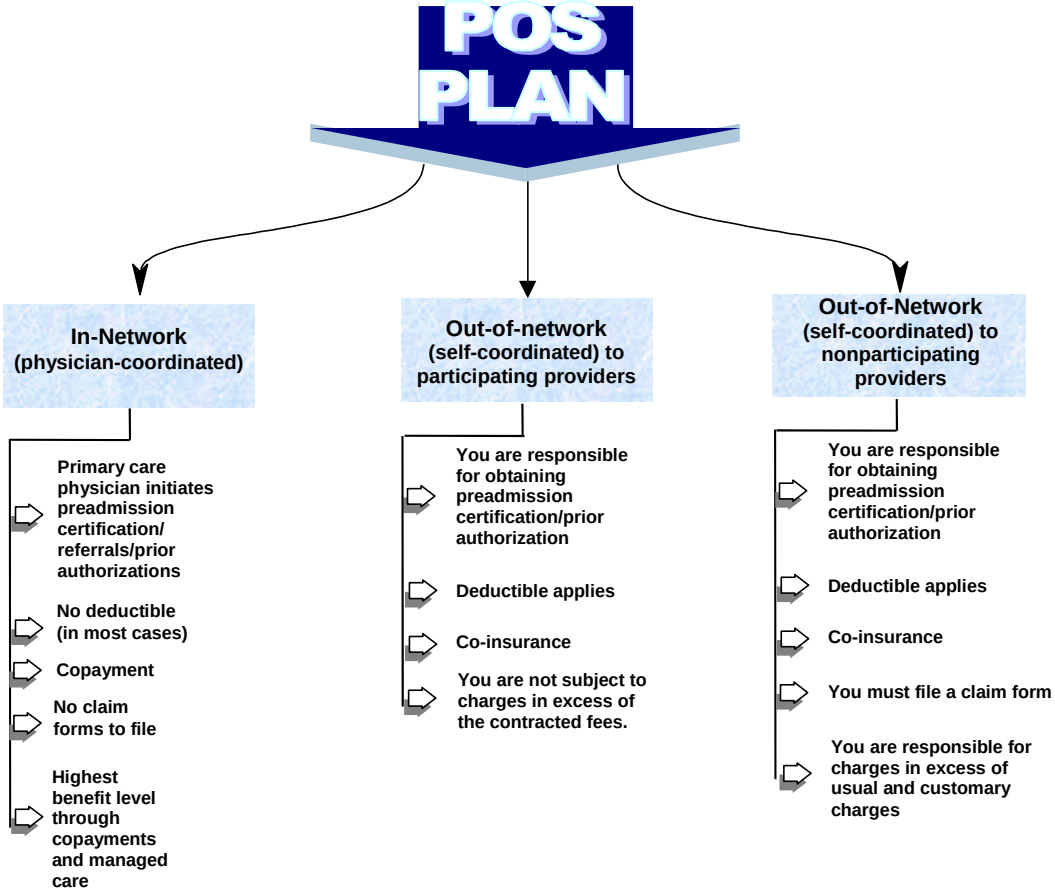
Any combination of days/visits used for covered services under either the in-network or out-of-network benefit option applies toward the calendar year maximums.

Under the out-of-network benefit, you may see any licensed provider of your choice. Covered out-of-network services are reimbursed after you meet an annual deductible of $500 for an individual or $1,500 for a family of three or more. After meeting the deductible, you will be reimbursed 70% of allowable charges (see Appendix A for the definition of "allowable charges"). The out-of-network benefit has a $3,000 annual individual out-of-pocket maximum and a $6,000 annual family out-of-pocket maximum. Amounts you pay in excess of allowable charges are not counted toward the out-of-pocket maximum. When you use out-of-network benefits, you are responsible for preadmission certification and prior authorizations, where required, and you are required to pay any amounts over allowable charges. You must file a claim in order to receive reimbursement.

NOTE: *If you access care through an in-network provider without obtaining a referral*, you will receive out-of-network benefits. You are also responsible for obtaining any preadmission certifications or prior authorizations required by the Plan; however, you will not be subject to charges in excess of the contracted fees.

When you receive care, show your identification (ID) card as proof of coverage. See Plan Benefits, page 25 and Accessing Care, page 45, for more information.

Your Plan choices for accessing medical care are represented in the following diagram.



IMPORTANT: You can access any option at any time during the year, whenever you need medical care.

Eligibility

This section outlines the service area for enrollment purposes as well as the eligibility requirements for active employees (and cost of coverage), retirees, other eligible persons, and dependents. Information on the cost of coverage for retirees and other eligible persons can be found under the section, Continuation and Conversions. It also provides information on coverage options when a Sandia employee/retiree is married to another Sandia employee/retiree, information concerning a Qualified Medical Child Support Order (QMCSO), and the eligibility appeals process.

NOTE: Eligibility, enrollment, premiums, contributions, or benefits may not be based on an employee's (or dependent's) medical condition, disability, evidence of insurability or other health factors.

Service Area

This Plan is available to employees and non-Medicare-primary retirees, other eligible persons, and their dependents who live or work within the designated zip codes listed in the CIGNA provider directories for New Mexico, Nevada, Washington D. C., Maryland, northern Virginia, and northern California.

When you *change your residence or work site* to **outside** of the service area, coverage will be terminated on the day of the change of residence or work site or the date of written notification to the Benefits Department, whichever is later, provided that Sandia Benefits is given written notification within 31 calendar days of the change. You may switch to the Top PPO Plan, the Kaiser HMO, the Basic PPO Plan, or the Intermediate PPO Plan, whichever is applicable, or drop coverage altogether. If written notification is not provided to the Sandia Benefits Department within 31 calendar days, you and your covered dependents will remain enrolled in the POS Plan. You will have emergency and urgent care, and out-of-network benefits available to you. Refer to Guest Privileges Program, page 63, for information on temporary job transfers and enrollment in the Guest Privileges Program under the POS Plan.

If you are enrolled in another plan, and you change your residence or you have a change in your work site to **within** the service area, you may elect to enroll yourself and your covered dependents in the POS Plan provided that written

notification is given to Sandia Benefits within 31 calendar days of the change in residence or work site. Coverage will be effective on the day of the change in residence and/or change in work site or the date of written notification to the Benefits Department, whichever is later.

NOTE: If you are enrolled in the POS Plan in Washington, D.C., or another site that is within the service area and you move to Albuquerque or from Albuquerque to another site that is still within the service area of this Plan, you will not be eligible to switch plans or drop coverage.

Active Employees

You are eligible to participate in this Plan beginning on the day you report for active employment if you live or work in the service area at the time of enrollment and you are a

- Regular, full- or part-time employee as classified by Sandia for payroll purposes,
- Limited-term exempt or nonexempt staff member or postdoctoral appointee,
- Faculty sabbatical appointee **not** eligible for other group health care coverage, or
- Nonrepresented year-round student who is enrolled in a post-secondary educational program and who is not covered by another medical plan (see the definition of "post-secondary educational program" in Appendix A, Acronyms and Definitions.)

NOTE: If you are graduating from high school, you have 31 calendar days following your reclassification to a high school graduate to enroll based on proof of enrollment provided to the Student Intern Program Office.

For purposes of coverage under this Plan, except for the employees identified immediately below, an individual is a covered "employee" only if

- The individual satisfies all other tests for coverage under this Plan,
- Sandia Corporation actually withholds required federal, state, or FICA taxes from the employee's paycheck,
- Sandia Corporation issues the employee a W-2 for the year in which a medical service is provided under the Plan, and
- Sandia Corporation issues the above W-2 no later than the year following the year in which the medical service was provided.

An employee who is receiving benefits under Sandia Corporation's Job-Incurred Accident Disability Plan, who otherwise satisfies the eligibility requirements of this Plan, is a covered "employee" for purposes of coverage under this Plan.

IMPORTANT **Employees who participate in the POS Plan do not participate in any other Sandia-sponsored medical plan. The option to choose participation is available during the Open Enrollment period held each fall.**

Employee Contributions

Sandia pays the majority of the costs for the POS Plan; however, all enrolled employees pay a monthly cost for coverage in this Plan. Refer to your open enrollment booklet or new hire binder, or call the Benefits Customer Service Center (BCSC) to find out your monthly cost. Monthly costs for represented employees are outlined in their bargaining agreement. The monthly cost-sharing amount is deducted from your bi-weekly paycheck in two equal installments each month. Employees have the opportunity to enroll in the Pre-Tax Premium Plan to pay for these costs on a pre-tax basis upon initial enrollment or during the annual Open Enrollment period. Refer to the Pre-Tax Premium Plan booklet for more information.

NOTE: Part-time employees working 20 hours a week pay one-half the full premium cost.

Retirees

You are eligible to participate in this Plan if you

- Are a retired employee under age 65,
- Are not eligible for Medicare primary coverage, and
- Live in the service area at the time of enrollment.

If you are a retiree and you and/or your covered dependents are eligible for Medicare primary coverage, coverage is provided for the Medicare-eligible member through the Lovelace Senior Plan (LSP) (within certain zip codes in New Mexico).

NOTE: If you live in a ZIP code area that is not covered under the LSP, you and your covered dependents will have to disenroll from the POS Plan and enroll in another Sandia-sponsored medical plan to continue coverage through Sandia.

Tip

If you are a retiree, to prevent any lapse in coverage from the POS Plan to the LSP, you and your covered dependents should apply for Medicare coverage as soon as you become eligible.

IMPORTANT **You must provide Sandia with a copy of your Medicare card showing you have both Medicare Parts A and B by the first of the month prior to the month in which you will be eligible for Medicare primary coverage.**

Tip

Contact the Sandia BCSC at 845-BENE (2363) for information on retiree contributions. More information on retiree contributions can be found under the section, Continuation and Conversions.

You and/or your covered dependents must have both Medicare Parts A and B to be eligible for enrollment in the LSP. If you and/or your covered dependents are eligible for Medicare primary coverage and you do not elect Medicare Parts A and B, you and/or your covered dependents are not eligible for medical coverage through Sandia until you have obtained Medicare Parts A and B. Coverage will not be retroactive for the period prior to obtaining Medicare Parts A and B.

IMPORTANT **Retirees who participate in the POS Plan do not participate in any other Sandia-sponsored medical plan. The option to choose participation is available during the Open Enrollment period held each fall.**

Dual Sandians

If you are a Sandia employee/retiree married to another Sandia employee/retiree, you may elect to cover yourself as

- An individual,
- A dependent of your Sandia spouse, or
- The primary covered member with your Sandia spouse as a dependent.

If the primary member is an employee, cost sharing of monthly contributions is based on the salary tier of the Sandia employee. If the primary member is a retiree, cost sharing of monthly contributions is based on the retiree contribution rate. If you and your Sandia spouse elect to be covered separately, you may each choose different medical plans, and any eligible dependents may be covered under either spouse; that is, some dependents may be enrolled under one spouse while other dependents are enrolled under the other spouse. No one (employee/retiree or eligible dependent) may be covered as both a primary member and a dependent or as a dependent under two different Sandia employees/retirees.

Tip

Contact the Sandia BCSC at 845-BENE (2363) if you have questions about eligibility or costs of coverage.

Other Eligible Persons

You are also eligible if you reside in the service area at the time of enrollment, and you are

- An employee who is not Medicare primary (see Continuation and Conversions, page 79) on certain leaves of absence;

NOTE: An employee on inactive status because he/she is on such a Sandia Corporation approved leave of absence, as evidenced by the written approval required for such leave, who otherwise satisfies the eligibility requirements of this Plan, is a covered "employee" for purposes of coverage under this Plan. See Active Employees, page 8.

- A non-Medicare-primary surviving spouse of a regular employee or retiree (see Coverage for the Surviving Spouse and Dependents on page 83);
- A non-Medicare-primary, long-term disability terminee (see Continuation and Conversions, page 79); or
- A non-Medicare-primary member who elects and pays for temporary coverage and pays the appropriate premium when required (for COBRA information, see Continuation and Conversions, page 79).

Other eligible persons who participate in this Plan do not participate in any other Sandia-sponsored medical plan. The option to choose participation is available during the Open Enrollment period held each fall. Call the Sandia BCSC at 845-BENE (2363) if you have questions about the costs of coverage.

Eligible Dependents

CIGNA periodically may require continuing proof of eligibility for your unmarried child who is covered because of physical or mental impairment.

If you are the primary covered member (see definition in Appendix A, Acronyms and Definitions) under the Plan, your Class I dependents eligible for participation include your

- Spouse, not legally separated or divorced from you;
- Unmarried child under age 19;
- Unmarried child over age 18 but under age 24 who is financially dependent on you;
- Unmarried child of any age who, because of physical or mental impairment,
  - is incapable of self-sustaining employment,
  - lives with you or in an institution or in a home that you provide, and
  - is financially dependent on you;

NOTE: Apply for coverage **within 31 calendar days** of your child becoming eligible. Forms are available from the BCSC. CIGNA determines if the applicant is disabled and eligible for coverage and notifies the member and Sandia accordingly.

- Unmarried child who is recognized as an alternate recipient in a QMCSO.

NOTE: If you are an employee or retiree enrolled or eligible for enrollment, you may enroll your child pursuant to a QMCSO. Refer to Qualified Medical Child Support Order, page 13.

See Appendix A, Acronyms and Definitions, for definitions of "child(ren)," "financially dependent persons," "living with you," "alternate recipient," and "qualified medical child support order."

Class II dependents are not eligible to enroll in this Plan.

Covered dependents who are eligible for Medicare primary coverage are provided coverage through the LSP provided they have both Medicare Parts A and B.

NOTE: The LSP is available only in certain ZIP codes in New Mexico. If you live in a ZIP code area that is not covered under the LSP, you and your covered dependents will have to disenroll from the CIGNA Network POS Plan and enroll in another applicable Sandia-sponsored plan to continue coverage through Sandia.

You must provide Sandia with a copy of your Medicare card showing you have both Medicare Parts A and B by the first of the month prior to the month in which you will be eligible for Medicare primary coverage.

If the covered dependent is eligible for Medicare primary coverage and does not enroll in both Medicare Parts A and B, he or she will not be eligible for coverage until the covered dependent obtains Medicare Parts A and B. Coverage will not be retroactive for the period prior to obtaining Medicare Parts A and B. Notify the Sandia BCSC at 845-BENE (2363) if you have a covered dependent who becomes eligible for Medicare primary benefits.

Under this Plan, you cannot be covered as both a dependent and a primary covered member, or as a dependent of more than one primary covered member, or as a dependent under more than one Sandia-sponsored medical plan.

To remain eligible, covered members must meet the definition of employee or dependent (see Eligible Dependents, page 11) and not have had Plan coverage previously terminated for cause (see page 77).

Qualified Medical Child Support Order (QMCSO)

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of any child of a participant (as defined by ERISA) who is recognized as an alternate recipient in a Qualified Medical Child Support Order (QMCSO). This Plan will comply with the terms of a QMCSO. A QMCSO is an order or judgment from a court or administrative body directing the Plan to cover a child of an eligible employee or retiree under a group health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected eligible employee or retiree and each child (or the child's representative) covered by the order will be given notice of the receipt of the order. The Sandia Legal Division will review the order and notify you within forty (40) business days of the date of notice to Sandia of their review. Coverage under the Plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions, please contact the Sandia BCSC at 845-BENE (2363). You have the right to obtain a copy of the procedures governing qualified medical child support orders at no charge.

Eligibility Appeal Procedures

If CIGNA denies your or a dependent's claim because of eligibility, you may contact the Sandia BCSC at 845-BENE (2363) to request a review of eligibility status. Written notification will be sent to you informing you of the decision within three (3) business days of your request. If you are not satisfied with the decision, you may request that your or your dependent's eligibility status be reviewed by the Employee Benefits Committee (EBC), which you must do in writing within 180 calendar days of the date of the letter informing you of the decision. The EBC has the exclusive right to interpret and apply the eligibility provisions of this Plan, to construe its terms, and to determine member eligibility thereunder; however, the determination of a dependent (due to a physical or mental impairment) for the purpose of determining eligibility under the Plan is the responsibility of the CIGNA. The determination of the EBC is conclusive and binding. You will be informed of the EBC's decision in writing within sixty (60) calendar days of the date the appeal was received; however, the EBC can request an additional sixty (60) days if special circumstances apply. You must exhaust the appeals process before you pursue any legal recourse.

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Enrollment & Disenrollment

This section outlines the enrollment procedures for new hires, reclassified employees, active employees, and retirees, as well as how to enroll and disenroll dependents. It also provides information on making mid-year election changes and the option to waive/drop coverage altogether.

New Hires/Reclassified Employees

As a new hire or reclassified employee **newly eligible** for medical coverage, you can elect to enroll yourself and your eligible dependents in the CIGNA Network POS Plan **within 31 calendar days of your date of hire or reclassification**. You will be given an enrollment form and payroll deduction card to complete.

To enroll:

- Complete the Medical Insurance Enrollment Form (Form SF4400-MED on the Web).
- Keep a copy as proof of coverage until you receive your CIGNA Network POS Plan ID card(s).
- Complete the payroll deduction card (Form SF4811-HCC on the Web), making sure you indicate whether you want your premium to be deducted on a pre-tax or after-tax basis. Refer to the Pre-Tax Premium Plan booklet for more information.

  NOTE: If you do not indicate pre-tax or after-tax on the payroll deduction card, your premium will automatically be taken pre-tax.

- Mail the form and payroll deduction card to Sandia BCSC at MS 1022.

IMPORTANT **Reclassified employees who already have medical coverage are not eligible to switch plans upon reclassification. Reclassified employees who have previously waived medical coverage are also not eligible to enroll until Open Enrollment.**

If you enroll in the CIGNA Network POS Plan within 31 calendar days, coverage will be retroactive to your date of hire or reclassification. If you do not enroll yourself and your eligible dependents within 31 calendar days of becoming a new hire or a reclassified employee newly eligible for medical coverage, you will be able to enroll yourself and your eligible dependents in the Basic PPO Plan (so long as you enroll within six months of your new hire or reclassified date). Coverage will be retroactive to your date of hire or reclassification. You will not be allowed to enroll yourself and your eligible dependents if there has been an intervening Open Enrollment period when you could have enrolled.

NOTE: If your effective coverage date is prior to the 16th of the month, you will be required to pay the applicable cost-share amount for the entire month in which you were hired or reclassified. If your effective coverage date is after the 15th of the month, you will **not** be required to pay the cost-share amount for the month in which you were hired or reclassified.

NOTE: If you terminate employment and are rehired within 30 days, you (and any covered dependents at the time of disenrollment) will automatically be reinstated into the CIGNA Network POS Plan. If you terminate employment and are rehired after 30 days, you may elect to be automatically reinstated to your prior election or you may make a new election.

Active Employees and Retirees

Eligible persons may elect to enroll in this Plan once a year during the Open Enrollment period held each fall. If you enroll in the CIGNA Network POS Plan during Open Enrollment, your coverage will be effective January 1 of the following calendar year. Refer to Service Area, page 7, for information on enrolling or disenrolling in the CIGNA Network POS Plan if you change your residence or have a change in work site to within or outside of the service area.

NOTE: If you are already enrolled in the CIGNA Network POS Plan and you wish to remain enrolled in this Plan for the subsequent calendar year, you do **not** need to enroll again through the Open Enrollment phone system.

Employees and retirees may also enroll if they experience a loss of coverage during the year due to:

- **Loss of eligibility under another plan** – An eligible employee or retiree (and/or his/her dependents) who declined coverage when initially eligible because of having other comprehensive medical coverage, and who later

loses the other coverage, may apply for coverage for himself/herself and eligible dependents within 31 calendar days of this event.

- **COBRA is exhausted after coverage under another plan** – An eligible employee or retiree (and/or his/her dependents) who has exhausted coverage under another plan outside Sandia, may apply for coverage for himself/herself and eligible dependents within 31 calendar days of this event.

- **Employer contributions to other coverage end** – An eligible employee or retiree (and/or his/her dependents) for whom employer contributions to the other plan in which he/she is enrolled have ended may apply for coverage for himself/herself and eligible dependents within 31 calendar days after coverage ends.

Retirees and/or their covered dependents who are eligible for Medicare primary coverage will be enrolled in the LSP so long as they have both Medicare Parts A and B.

NOTE: The LSP is available only in certain ZIP codes in New Mexico. If you live in a ZIP code area that is not covered under the LSP, you and your covered dependents will have to disenroll from this Plan and enroll in another Sandia-sponsored medical plan to continue coverage through Sandia.

You must provide Sandia with a copy of your Medicare card showing you have both Medicare Parts A and B by the first of the month prior to the month in which you will be eligible for Medicare primary coverage.

Enrolling Dependents

Notify the Sandia BCSC at 845-BENE (2363) in New Mexico or 510-294-2254 in California as soon as you gain an eligible dependent. All Class I dependents must be enrolled with the Sandia BCSC at 845-BENE (2363) **within 31 calendar days** of their eligibility or an election change event whether or not your premium is taken pre-tax or after-tax (refer to the Pre-Tax Premium Plan Booklet for election change events). You can also enroll eligible dependents during the Open Enrollment period held each fall.

The following information must be provided upon enrollment:

- Dependent name and relationship to you,
- Date of birth, and

- Social Security number (not applicable to newborns).

If the eligible Class I dependent has other health insurance coverage upon becoming eligible for the CIGNA Network POS Plan and declines enrollment, and if in the future he or she involuntarily loses that coverage, you may be able to enroll the Class I dependent, provided that you request enrollment within 31 calendar days of the loss of coverage.

Coverage for eligible dependents becomes effective on the latter of

- The date of effective coverage for the employee or retiree, or
- The date of the mid-year election change event affecting dependent eligibility, or
- The date written notification is received by the Benefits Department to enroll a dependent due to a mid-year election change event.

NOTE: If enrolling a dependent due to a birth, adoption, or placement for adoption, the coverage becomes effective on the date of the birth, adoption, or placement for adoption. You must enroll the dependent within 31 calendar days.

NOTE: If you enroll a new dependent and your cost-share amount changes, the following will apply:

- If the effective coverage date for your new dependent is before the 16th of the month, you will be required to pay the new applicable cost-share amount for that entire month.
- If the effective coverage date for your new dependent is after the 15th of the month, you will NOT be required to pay the new applicable cost-share amount for that month.

If you do not enroll your eligible dependent within 31 calendar days of a marriage, birth, adoption, placement for adoption, or obtaining legal guardianship, you will be able to enroll your eligible dependent in the CIGNA Network POS Plan within six months of the marriage, birth, adoption, placement for adoption, or obtaining legal guardianship, but you will have to pay the applicable premium-share on an after-tax basis. You will not be eligible to enroll your dependents if there has been an intervening open enrollment period when the dependent(s) could have been enrolled. If the enrollment does not cause any change to your premium-share amount, for example, you are already paying for a family of three or more, you will be able to enroll the dependent at no additional cost to you. If you elect coverage under this option, you must remember to enroll

your eligible dependent during the next Open Enrollment period in order to have coverage in the subsequent calendar year. Coverage for dependents gained as a result of marriage or legal guardianship will be effective on the data of enrollment and you will pay premiums from that day forward. Coverage for births, adoptions, or placements for adoption will be retroactive to the event and premiums will be charged retroactively.

NOTES:

1. Newborn dependent children are automatically covered for the first 31 calendar days but must be enrolled with the Sandia BCSC within 31 calendar days of their birth to continue coverage. Call the BCSC at 505-845-BENE (2363) for enrollment instructions.

2. Coverage for an adopted child whom you enroll with the Sandia BCSC begins when the child is placed with you for adoption so long as written notification and the placement agreement and/or final adoption papers are received by the BCSC within 31 calendar days of the placement for adoption. Medical expenses of the child before adoption, including the birth mother's prenatal, postnatal, and delivery charges are not covered.

To Enroll an Eligible Dependent

To enroll an eligible Class I dependent (refer to Eligible Dependents, page 11),

- Complete the Medical Insurance Enrollment form (Form SF4400-MED) on the Web.

  NOTE: Newborns do not need to have a Social Security number to be enrolled.

- Retain a copy for your files, and
- Mail the original to the Sandia BCSC at MS1022.

IMPORTANT **Dependents must be enrolled within 31 calendar days of their eligibility or election change event.**

Forms are available from the Sandia BCSC at 845-BENE (2363) or the Web. To access the forms on the Web, click on the Form/Template icon. Next, click on Corporate Forms, select "Benefits" from the left column, and select the Medical

Insurance Enrollment form. If your premium share will change, you also have to complete the payroll deduction card (Form SF4811-HCC).

You must enroll your eligible dependents within 31 calendar days in the dental and vision Plans separately by using a separate form, which is available from the Sandia BCSC or the Web under "SF4400-ADV."

Disenrolling Dependents

If you are a retiree, or an employee who is having the medical premium deducted from your paycheck on an **after-tax basis**, you can disenroll your covered dependents at any time during the year; however, if a Class I covered dependent loses eligibility, you must notify the Sandia BCSC **immediately**. The effective date of disenrollment will be the last day of the month in which the covered dependent became ineligible.

If you are an employee who is having the medical premium deducted from your paycheck on a **pre-tax basis**, you must disenroll a covered Class I dependent if the covered Class I dependent loses eligibility or you can disenroll a covered Class I dependent upon an election change event. You must disenroll the covered dependent within 31 calendar days of the loss of eligibility or mid-year election change event. Refer to the Pre-Tax Premium Plan booklet for more information.

If you fail to disenroll your covered Class I dependent by the end of the month in which the covered dependent became ineligible, coverage for your ineligible dependent will be retroactively terminated to the last day of the month in which the covered dependent became ineligible, and you will be responsible for reimbursing Sandia for any claims incurred after your dependent lost eligibility. You may also be subject to disciplinary action for fraudulent use of the Plan.

If you or your ex-dependent notify Sandia of the loss of eligibility of the dependent after the 60-day notification period for COBRA has expired, the ex-dependent will not be entitled to continue coverage through Sandia under COBRA.

To Disenroll a Dependent

To disenroll a Class I dependent (refer to Eligible Dependents, page 11),

- Complete a Medical Insurance Dependent Disenrollment form.

- Retain a copy for your files, and
- Mail the original to the Sandia BCSC at MS1022.

Dependents must be disenrolled within 31 calendar days of their loss of eligibility.

Forms are available from the Sandia BCSC at 845-BENE (2363) or the Web. To access the forms on the Web, click on the Form/Template icon. Next, click on Corporate Forms, select "Benefits" from the left column, and select the Medical Insurance Dependent Disenrollment form.

If your dependent also becomes ineligible for dental and vision coverage, you need to complete a separate form, which is available from the Sandia BCSC or the Web under "SF4400-DVD."

Sandia abides by a federal law referred to as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1987 in which temporary continued coverage is provided to dependents who would otherwise lose group coverage because of specified events. Refer to Continuation and Conversions, page 79, for more information. However, failure to disenroll your dependent in a timely manner as described above will result in loss of COBRA rights.

Election Change Events Allowing Mid-Year Election Changes

Mid-year election change events may permit changes to your health care coverage election at times other than during Open Enrollment so long as written notification is provided to the BCSC, MS 1022, within 31 calendar days of the election change event and the mid-year election change is consistent with the event. Generally, the new election is effective on the **later** of the status change date or the date of written notification to the Benefits Department. In the case of a birth, adoption, or placement for adoption, the coverage will be retroactive to the event subject to enrollment rules. In the case of disenrollment due to ineligibility, the effective date will be the last day of the month in which the covered dependent became ineligible. In the case of disenrollment for any other reason, the effective date will be the last day of the month in which written notification was received by the Benefits Department. Refer to the Pre-Tax Premium Plan booklet for more information.

NOTE: These mid-year election changes allowing enrollment apply whether your medical premium is deducted pre- or after-tax.

Waiving/Dropping Coverage Altogether in Sandia-Sponsored Medical Plans

You have the option to waive coverage for yourself and your covered dependents during the annual Open Enrollment period held each fall. If your premiums are deducted on an **after-tax basis**, you may also drop coverage for yourself and/or your covered dependents at any time during the year. If your premium is deducted on a **pre-tax basis**, you can drop coverage for yourself and your covered dependents outside of the Open Enrollment period held each fall only if you experienced a mid-year election change event. Refer to the Pre-Tax Premium Plan booklet for more information.

IMPORTANT **If you are a surviving spouse and you waive or drop coverage, you can never re-enroll in a Sandia-sponsored medical Plan.**

Coverage for any eligible dependent is based on your coverage as an employee; therefore, if you waive/drop coverage for yourself, you are also waiving/dropping coverage for all of your covered and/or eligible dependents. Coverage will end on the last day of the month in which you waive/drop coverage. If you waive/drop coverage, you will have the option to reinstate during the Open Enrollment period held each fall with coverage becoming effective January 1 of the following calendar year.

Under the Health Insurance Portability and Accountability Act (HIPAA), if you waive/drop coverage for yourself and your covered dependents because of having other health insurance coverage, and you and your covered dependents involuntarily lose eligibility for that coverage, you may be able to enroll yourself and your eligible dependents during the Plan year, provided that you request enrollment within 31 calendar days after the other coverage ends. In addition, if you acquire a new eligible dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 31 calendar days after the marriage, birth, adoption, or placement for adoption.

Tip

Contact the Sandia BCSC at 845-BENE (2363) for the required forms to disenroll and/or enroll in the CIGNA Network POS Plan.

Employees enrolled in the CIGNA Network POS Plan have the **option** to cancel their coverage upon meeting the requirements of the Family and Medical Leave Act (FMLA). Written notification to cancel coverage must be received by the Sandia BCSC within 31 calendar days of the first day of absence. If you choose to cancel coverage, coverage will cease at the end of the month in which the BCSC receives written notification. If you do not cancel the coverage, coverage will be continued, and premiums will continue to be deducted (on a pre-tax or after-tax basis) during sickness absence, or made up upon return from an unpaid

absence. If your absence is classified as a Leave of Absence, you will receive paperwork from the Sandia BCSC to continue paying your premiums monthly, on an after-tax basis. If you do not continue to pay premiums during a Leave of Absence, your coverage will be canceled.

If you do not cancel your coverage during sickness absence or an unpaid absence and you return in a subsequent calendar year, premiums not taken will be made up on an after-tax basis.

An employee can reenroll by notifying the Sandia BCSC in writing within 31 calendar days of returning to work. If notification to the Sandia BCSC to reinstate medical coverage for you and your eligible dependents is not received in writing within 31 calendar days of the date you return from the absence, you cannot reinstate medical coverage until the following calendar year, provided that the election is made during the next applicable Open Enrollment period.

NOTE: Members who voluntarily terminate Plan coverage for themselves and their covered and/or eligible dependents while still employed with Sandia will not be eligible for any COBRA continuation or individual conversion.

If you are planning to take paid or unpaid time off, contact the Sandia BCSC at 845-BENE (845-2363).

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Plan Benefits

This section outlines the in- and out-of-network benefits, limitations, and exclusions. The CIGNA Network POS Plan does **not** have a preexisting clause that would limit coverage for participants enrolling in the Plan with a preexisting medical condition.

IMPORTANT **Any combination of days/visits used under either the in-network or out-of-network option applies toward the calendar-year maximums. For example, if you receive 20 visits under the in-network outpatient substance abuse rehabilitation benefit and you opted to use the out-of-network benefits for the remainder of your care, you would be limited to ten visits out-of-network for the remainder of the calendar year.**

In-Network Benefits

The physician-coordinated in-network benefit gives you the highest benefit level through copayments and managed care. You pay $10 for most in-network office visits. There are no deductibles or coinsurance (with the exception of external prosthetic appliances), and, in most cases, there is no need to file a claim form. To protect you and your covered dependents from the high cost of catastrophic illness, there is a maximum on the total copayments/coinsurance you must pay in a calendar year. Your annual individual out-of-pocket maximum is $1,500, and your annual family out-of-pocket maximum is $3,000. If you reach this maximum, notify CIGNA Member Services at 800-CIGNA24 (800-244-6224) so that you will not incur any additional out-of-pocket expenses for covered services rendered during the remainder of the calendar year under the in-network benefit. See pages 28 through 44 for in-network benefits, copayments/charges, limitations, and exclusions.

NOTE: Outpatient prescription drug costs, behavioral health costs, and amounts you pay in excess of allowable charges are not included in your out-of-pocket maximum. Refer to Appendix A, Acronyms and Definitions, for the definition of "allowable charge."

IMPORTANT **If a member has coverage through Sandia and coverage under another employer group health plan, this Plan will not waive the copayments for prescription drugs and behavioral health benefits.**

Prescription Drug Formulary

The CIGNA Network POS Plan maintains a closed formulary, which means that physicians must prescribe medications from the formulary list. Exceptions can be made to the formulary by the physician in certain cases (prior history, combination of medications, etc.) with approval of the Pharmacy Administration Department.

The CIGNA HealthCare Drug Formulary is developed and maintained in accordance with the recommendations of our National Pharmacy and Therapeutics Committee. This committee, comprised of physicians and pharmacists, meets every quarter to review new drugs and determine formulary positioning.

Through the National Pharmacy and Therapeutics Committee review process, drugs may be added to the formulary on an ongoing basis, consistent with their meeting schedule. Drugs may be removed from the formulary no more frequently than at the start of the calendar year, with one exception (described in the next paragraph).

The National Pharmacy and Therapeutics Committee will consider deleting a drug from the formulary should new evidence become available concerning the safety of a formulary drug. The Committee may delete a drug for safety reasons at any time during the year.

All newly approved drugs are designated nonformulary/nonpreferred until the National Pharmacy and Therapeutics Committee evaluates the drug clinically and considers formulary placement. Drugs that are assigned a "P" status, which is a drug that represents an advance over available therapy by the Food and Drug Administration (FDA), will be reviewed by the Committee within six months of FDA approval. Drugs that are assigned "S" status, which is a drug that appears to have therapeutic qualities similar to those of an already marketed drug by the FDA, will not be reviewed by the Committee for at least twelve months following FDA approval.

In certain cases in which clinical data on a priority review drug are so compelling that a clinical determination is warranted in an expedited timeframe, an ad hoc group will be formed with representation from Medical Strategy and Health Policy, Care Management, Med/Tech Assessment and the Pharmacy Council to

review the clinical evidence and make an interim determination on the clinical merits of the drug.

Out-of-Network Benefits

Out-of-network coverage allows you to self-refer to any licensed provider or facility within or outside of the CIGNA network, but a number of coverage limits apply (see Services Not Covered Under the Out-of-Network Benefit, below). You must pay for services rendered and file a claim for reimbursement (see Filing Your Claims, page 69). You are subject to a $500 annual individual deductible or a $1,500 annual family deductible before any benefits are paid. For medically necessary and covered services, you will be reimbursed 70% of allowable charges (see Appendix A for definition of "allowable charges") for most services. The covered member is responsible for any charges that exceed the allowable charges. You will receive 100% reimbursement of allowable charges upon meeting a $3,000 annual individual out-of-pocket maximum or a $6,000 annual family out-of-pocket maximum, but you are responsible for charges in excess of allowable charges. See pages 28 through 44 for out-of-network benefits, charges, limitations, and exclusions.

NOTE: Outpatient prescription drug costs, behavioral health costs, and amounts you pay in excess of allowable charges are not included in your out-of-pocket maximum.

NOTE: Deductibles, coinsurance and amounts you pay in excess of the allowable charges can be submitted for reimbursement under the Health Care Reimbursement Spending Account (see definition in Appendix A).

Services Not Covered Under the Out-of-Network Benefit

The following services are not covered out-of-network:

- The Employee Assistance Program
- Organ transplants
- Screening hearing/vision exams
- Mail-order drugs
- Sports physicals

Plan Coverages and Limitations

The following table details copayments, deductibles, and coinsurance for in-network and out-of-network benefits. Self-coordinated, in-network care falls under the out-of-network coverage column.

Deductible/ Out-of-Pocket Maximum	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)	Comments
Deductible	Not applicable (with the exception of external prosthetic appliances)	$500 annual individual $1,500 annual family	Copayments made under the in-network benefit do not apply to the out-of-network deductible. The out-of-network deductible does not cross-apply to the in-network deductible and vice versa.
Out-of-Pocket Maximum	$1,500 annual individual $3,000 annual family	$3,000 annual individual $6,000 annual family	Copayments made under the in-network benefit do not apply to the out-of-network, out-of-pocket maximum. The out-of-network, out-of-pocket maximum does not cross-apply to the in-network out-of-pocket maximum and vice versa.

All copayments are due at the time of service.

The following table details Plan coverages, copayments, deductibles, and coinsurance for in-network and out-of-network benefits.

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
Acupuncture Services for treatment of chronic musculo-skeletal or neurogenic pain	**See Short-Term Rehabilitation Therapies, page 39.**		
Allergy Treatment • Extract preparation • Office visit • Testing • Shot only	 No charge $10 per visit $10 per visit $10 per visit	30% of allowable charges for all categories	
Ambulance Service[2] (When an ambulance is necessary, call 911 or any other local ambulance service for transportation to an emergency room.)	No charge	Care will be covered at in-network levels only if it meets CIGNA's criteria for emergency care; otherwise not covered.	A covered benefit only when transportation in any other vehicle could endanger your health
Behavioral Health Care (administered by CIGNA Behavioral Health)	**Note:** Call CIGNA Behavioral Health at 800-335-5415, 24 hours a day, for an appointment or urgent/emergency care for EAP or in-network services.		
• Employee Assistance Program (EAP)	No charge	Not covered	Maximum of eight EAP visits per calendar year, including the initial visit
• Outpatient – mental health/substance abuse rehabilitation – Initial visit	 No charge	 50% of allowable charges	
• Mental health – office visit – group therapy	 $10 copay $10 per session	 50% of allowable charges 50% of allowable charges	

[1] Member is responsible for charges that exceed allowable charges.

[2] CIGNA will examine the ambulance/medical records to determine if ambulance transportation was medically necessary. Medical transportation services do not include transportation of covered persons by passenger car, taxi, bus, or other forms of public transportation. **You must submit the statement you receive from the ambulance service to CIGNA within 120 days from the date of service for consideration of in-network level of benefits.**

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
• Substance abuse			Maximum of 30 outpatient visits per calendar year for substance abuse rehabilitation.
– office visit	$10 copay	50% of allowable charges	
– group therapy	$10 per session	50% of allowable charges	
	Note: Visits used under the in-network and/or out-of-network benefit count toward the maximum of 30 outpatient visits.		
• **Inpatient – Mental Health** includes hospital, physicians, and other professional services			
– Inpatient	$250 copay per admission	50% of allowable charges[3]	Maximum of 60 inpatient days per calendar year or 120 partial hospitalization days.
– Partial	$125 copay per program	50% of allowable charges[3]	
	Note: Days used under the in-network and/or out-of- network benefit count toward the maximums.		
• **Inpatient – Substance Abuse Rehabilitation,**[4] includes hospital, physicians, and other professional services			
– Inpatient	$250 copay per admission	50% of allowable charges[3]	Maximum of 15 inpatient days per calendar year or 30 partial hospitalization days per calendar year
– Partial hospitalization	$125 copay per program	50% of allowable charges[3]	
	Note: Days used under the in-network and/or out-of- network benefit count toward the maximums.		

[3] Out-of-network hospitalization subject to preadmission certification and continued stay review. If you fail to obtain preadmission certification, you will incur a $500 benefit reduction in addition to the deductible.

[4] Detoxification is covered under the Hospital Admission benefit, limited to 3 days.

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
Breast Reconstruction, in connection with a mastectomy			Services (to be determined by consultation between the attending physician and the patient) are covered for members who receive benefits in connection with a mastectomy as follows: • Reconstruction of the breast on which the mastectomy was performed • Surgery and reconstruction of the other breast to produce a symmetrical appearance • Prosthesis and physical complications in all stages of mastectomy, including lymphedema. There are no limitations on the number of prostheses and no time limitations from the date of the mastectomy.
• Inpatient	$250 per admission	30% of allowable charges[3]	
• Outpatient surgery	$75 per visit	30% of allowable charges	
• Prostheses	$200 deductible, then no charge	30% of allowable charges up to a maximum of $1000 per calendar year (after individual annual deductible of $700)	
Cancer Screening	No separate charge for mammograms and proctoscopies ($10 office visit copay applies)	30% of allowable charges	Subject to American Cancer Society guidelines
Chiropractic Services	**See Short-Term Rehabilitation Therapies, page 39.**		

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
Dental Services[5, 6]			
• Craniomandibular and temporoman-dibular joint (TMJ) dysfunction conditions	$10 per visit $75 if outpatient surgery $250 per admission	30% of allowable charges[3]	TMJ services must be preapproved by the respective health plan's Medical Director or designee. Orthodontic treatment, crowns, bridges, and dentures are covered **only** if the injury is trauma-related.
• Emergency dental care	$10 per visit $75 if outpatient surgery $250 per admission	30% of allowable charges[3]	Emergency dental care is covered as a result of injury to sound, natural teeth, jaw bones or surrounding tissues. Treatment must be started within 6 months of the injury.
• Dental surgery	$10 per visit $75 if outpatient surgery $250 per admission	30% of allowable charges[3]	Coverage excludes any treatment that is considered primarily orthodontic in nature, dental x-rays, examinations, repairs, orthodontics, perio-dontics, casts, splints and services for dental malocclusion and dental treatment of the teeth.
	Note: Refer to the Dental Expense Plan/Dental Deluxe Plan SPD for information on covered dental services under these Plans		

[5] Treatment for mandibular or maxillary prognathism, micrognathism or malocclusion, and maxillary constriction, as well as dental treatment of the structures directly supporting the teeth are covered if the treatment is not considered cosmetic in nature, is considered medically necessary, is not dental in nature, and requires prior approval. Orthognathic surgery is covered only if medically necessary and requires prior authorization if under the out-of-network benefit. It is limited to documented skeletal Class II and Class III conditions as determined by cephalometric diagnosis, provided the condition is both functional and aesthetic and, in the opinion of an independent orthodontist selected by the Plan, is not adequately treatable by conventional orthodontic therapy.

[6] For injuries to sound natural teeth, the jaw bone, or surrounding tissue, this Plan is primary. If you or your covered dependents are enrolled in Sandia's Dental Expense or Dental Deluxe Plans, that Plan **may** provide additional coverage on a secondary basis.

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
Diabetic supplies such as: • Insulin • Monitors • Test strips • Lancets • Needles/syringes	See Prescription Drugs, page 38.		
Diagnostic laboratory tests and X-ray procedures (outpatient)	No charge	30% of allowable charges	
Durable Medical Equipment • Equipment (e.g., crutches) • Oxygen and oxygen equipment	No charge No charge	30% of allowable charges 30% of allowable charges	Rented or purchased when prescribed Prior approval recommended for out-of-network
Emergency Room Care	$50 per visit (waived if inpatient admission occurs as a result of medical emergency)	30% of allowable charges (care will be covered at in-network benefit level if it meets CIGNA's criteria)	See Definition and Examples of Medical Emergency, page 51. Coverage available worldwide.
External Prosthetic Appliances	$200 deductible then no charge (unlimited)	30% of allowable charges up to a maximum of $1,000/calendar year (after individual annual deductible of $700)	Prior approval recommended for out-of-network
Hearing Services • Routine screening exams • Hearing aids	$10 per visit Not covered	Not covered Not covered	Screening exam covered for members age 17 and under only to determine the need for hearing correction and must be performed by the member's PCP
Home Health Care • Physician house calls • Prescribed home nursing care	No charge No charge	30% of allowable charges 30% of allowable charges	

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
Hospice Care	No charge	30% of allowable charges	For specified hospice care services that are reasonable and necessary for the palliation or management of terminal illness
Hospital Admission • Semi-private room and board • Private room (when medically necessary) • Intensive care or coronary care • Use of the operating room, anesthesia, and general nursing • Physician, surgeon and anesthesi-ologist/nurse anesthetist services	$250 per admission	30% of allowable charges for all categories[3]	Out-of-network providers/facilities will bill separately. Refer to Out-of-Network Benefits, page 27.
Hospital Services • Medications • Injections • X-ray • Radiation therapy • Laboratory tests • Inhalation therapy • Casts and dressings • Administration of blood and blood derivatives	Included in the $250 hospital copayment	30% of allowable charges for all categories[3]	
Infertility Services • Lifetime maximum of $20,000 • Office visit (tests, counseling) • Outpatient facility • Inpatient facility • Surgical procedure to correct reason for infertility	 $10 per visit $75 per visit $250 per admission No charge after $200 per surgery copay	Not covered	Donor preparation, collection and storage of eggs or sperm, and drugs (other than oral medications) are not covered.

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
• Oral Infertility Drugs **See Exclusions for excluded services.**	See prescription drug benefit	30% of allowable charges	**Note:** Fertility drugs apply to lifetime maximum.
Maternity Care	Under federal law, mothers and their newborns who are covered under group health plans are guaranteed a stay in the hospital of not less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section.		
• Prenatal, delivery and postnatal care – visit to confirm pregnancy – all other visits – X-ray and lab services – prenatal vitamins	\$10 copay No charge No charge Not covered if can be purchased over the counter without a prescription	30% of allowable charges for all categories	Maternity services are provided for covered members **Note:** The newborn must be enrolled with the Sandia BCSC within 31 calendar days of the birth to continue coverage beyond the first 31 calendar days.[7]
• Hospital, labor and delivery services **See Newborn Care**	\$250 for first admission due to pregnancy; subsequent admissions related to same pregnancy, no charge	30% of allowable charges[3]	
Mental Health	**See Behavioral Health Care, page 29.**		
Minor surgery in Physician's Office	\$10 per office visit	30% of allowable charges	Refer to Out-of-Network Benefits, page 27.

[7] If the newborn is delivered by a covered member of this Plan but does not meet the eligibility criteria for a dependent under this Plan, expenses for the newborn will be covered under the global fee that is charged to the mother in connection with the delivery. Any expenses for the newborn that are billed separately under the newborn will not be covered under this Plan.

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
Newborn Care • Hospital nursery care services	Included in the mother's $250 hospital copayment	30% of allowable charges[3]	Maternity services are provided for covered members
• Physician visits while newborn is hospitalized	No charge	30% of allowable charges[3]	**Note:** The newborn must be enrolled with the Sandia BCSC within 31 calendar days of the birth to continue coverage beyond the first 31 calendar days.[7]
• Physician's services for outpatient well-baby care	$10 per visit	30% of allowable charges	
Occupational Therapy	**See Short-Term Rehabilitation Therapies, page 39.**		
Office Visits including but not limited to • Physician • Nurse practitioner • Physician assistant • Diagnosis and treatment • Specialist's care and consultation • Adult or pediatric checkups • Sports physicals • Minor surgery • Radiation therapy • Chemotherapy	$10 per visit (all categories)	30% of allowable charges (sports physicals not covered)	

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
Organ Transplants to include medical, surgical and hospital services, immunosuppressive medications and organ procurement for medically necessary covered organ transplants. See Provider Networks for information on the CIGNA LIFESOURCE Organ Transplant Network (page 46)	$10 per office visit $250 per admission **Note:** Covered for recipients who are covered members. All services must be nonexperimental and authorized by the respective health plan's Medical Director or designee based on medical criteria.	Not covered	Coverage for organ procurement costs is limited to costs directly related to the procurement of an organ from a cadaver or from a donor. Costs shall consist of surgery necessary for organ removal, organ transportation, and the transportation, hospitalization, and surgery of a live donor. Coverage for compatibility testing undertaken prior to procurement shall be limited to testing of cadavers and donors having a blood relationship to the recipient.
Other Services including but not limited to			Immunizations covered include those required for personal and business-related travel. **Employees** requiring immunizations for **business-related** travel need to contact the Medical Department at Sandia.
• Casts and dressings	$10 office visit copay	30% of allowable charges	
• Specified immunizations	$10 office visit copay	30% of allowable charges	
• Travel-related immunizations	$10 office visit copay	$10 office visit copay (no deductible)	
• Medication administration	$10 office visit copay	30% of allowable charges	
• Norplant insertion		30% of allowable charges	
– Office	$10 copay		
– Outpatient facility	$75 copay		
Outpatient Surgery • Facility • Surgeon • Anesthesiologist/ anesthetist	$75 per visit	30% of allowable charges for all categories	Refer to Out-of-Network Benefits, page 27.

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
Physical Therapy	**See Short-Term Rehabilitation Therapies, page 39.**		
Prescription Drugs (outpatient)	Retail Network Pharmacy: • $10 for generic • $20 for brand name • Maximum of 30-day supply or 100 units, whichever is less	30% of allowable charges	If the cost of the drug is less than the copay, you only pay the cost of the drug.
	Mail-Order: • $20 for generic • $40 for brand name • Maximum of 90-day supply or 300 units, whichever is less	Mail order not available	In-network: Brand name covered only if no generic is available or the physician writes "Dispense as written." This Plan has a mandatory generic provision. If a generic drug is available and you, the member, request a brand name drug, you will pay the brand name copay plus the difference between the average wholesale price of the brand name drug and the average wholesale price of the generic drug. In no event, will your cost exceed the retail price of the brand name drug.
Preventive Care • Routine physical exams • Cancer screening • Well baby care • Immunizations	 $10 per visit No additional charge $10 per visit $10 per visit	 30% of allowable charges 30% of allowable charges 30% of allowable charges 30% of allowable charges	Routine physical exams are covered as appropriate to your age, gender, and medical history. Cancer screenings are subject to American Cancer Society guidelines.

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
Rehabilitation Hospital including but not limited to • Physical therapy • Occupational therapy • Speech therapy • Nursing care	No charge	30% of allowable charges for all categories[3]	Combined maximum with skilled nursing care facility of 60 days per calendar year. Post-hospital, intensive, acute rehabilitation provided at acute hospital or skilled nursing facility.
	Note: Days used under the in-network and/or out-of-network benefit count toward the maximum.		
Short-Term Rehabilitation Therapies (outpatient services) • Acupuncture • Chiropractic • Occupational • Physical • Speech	$10 per visit	30% of allowable charges for all categories	Combined maximum of 60 visits per calendar year
	Note: Visits used under the in-network and/or out-of-network benefit count toward the maximum.		
Skilled Nursing Care Facility including but not limited to • Room and board • Laboratory tests • X-rays • Physician's services • Therapies • Medications	No charge	30% of allowable charges for all categories[3]	Combined maximum with rehabilitation hospital of 60 days per calendar year
	Note: Days used under the in-network and/or out-of-network benefit count toward the maximum.		
Speech Therapy	**See Short-Term Rehabilitation Therapies, above.**		
Substance Abuse	**See Behavioral Health Care, page 29.**		

Benefit	In-network (copays or charges the member pays)	Out-of-network (coinsurance the member pays subject to the deductible)[1]	Comments
Urgent Care/ Nonappointment Care			
• Appointment/office visit	$10 per visit	30% of allowable charges (care will be covered at in-network benefit level if it meets CIGNA's criteria)	Refer to Emergency/ Urgent Care, page 51. Coverage available worldwide.
• Urgent care facility	$25 per visit		
• Emergency room	$50 per visit		
Vision Services			
• Routine screening exams	$10 per visit	Not covered	Eye screening exams available for members age 17 and under only.
• Prescription lenses[8]	Not covered	Not covered	
• Medically necessary eye exam	$10 per visit	30% of allowable charges	Emergency outpatient care, and inpatient care for medically necessary vision services for the diagnosis and treatment of injuries or diseases of the eye is covered.
• Outpatient surgery	$75 per visit	30% of allowable charges	
• Inpatient	$250 per admission	30% of allowable charges[3]	

Note: The Sandia Vision Care Plan is available to regular employees and their dependents for routine refractive vision care. Refer to the Vision Care Plan SPD for more information about covered vision benefits.

Exclusions: What the Plan Does Not Cover

Although the Plan provides benefits for a wide range of medical services, you should be aware that, as with all group health plans of this type, there are exclusions. These exclusions include, but are not limited to, those shown (in alphabetical order) in the following table.

Exclusions	Examples
Ancillary Services	• Nonmedical ancillary services such as – Vocational rehabilitation – Behavioral training – Sleep therapy – Employment counseling – Psychological counseling

[8] Contact lenses are covered only for the medically necessary treatment of keratoconus when authorized by the respective health plan's Medical Director or designee. The initial pair of contact lenses following cataract surgery is also covered.

Exclusions	Examples
	– Training or educational therapy for learning disabilities or mental impairment.
Cosmetic Surgery	Treatments or drugs for cosmetic purposes, unless determined by the respective health plan's Medical Director or designee to be medically necessary for treatment of a functional organic disorder (for example, repair of certain birth defects or defects resulting from disease or injury).
Custodial Care	Care including, but not limited to, the meeting of personal needs that can be provided by persons without professional skills or training, such as providing assistance with walking, getting into or out of bed, bathing, dressing, eating, and taking medication. (See definition in Appendix A, Acronyms and Definitions.)
Dental Procedures	• Orthodontic treatment and appliances, crowns, bridges, and dentures that are **not** trauma related. • Dental care, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, and splints for sound, natural teeth, jaw bone, and surrounding tissue, is not covered unless services required are due to injury. • TMJ services received by a covered member that have **not been approved** by the Medical Director or designee. Refer to page 32 for covered dental services.
Donor Expenses	• Medical and hospital services of a donor when the recipient of an organ transplant is not a covered member or when the transplant procedure is not a covered benefit. • Donor expenses in connection with infertility are not covered (see [Infertility Treatment, page 42]).
Drugs and Medical Supplies	• Drugs and medicines that are purchased without a physician's prescription. • Over-the-counter medication. • Medical supplies (including those purchased over the counter without a prescription) except when provided as a covered inpatient service or during a physician office visit or authorized home health service visit. • Services not primarily medical in nature or supplies or equipment that are primarily and customarily used for a nonmedical purpose.
Experimental or Investigative Treatment	Experimental services or investigative procedures or protocols, including drugs or equipment. Experimental or investigative procedures are ones that are not obtainable outside an investigative setting, do not have final approval from appropriate government regulatory bodies for clinical use, or are not commonly and customarily recognized throughout the medical profession as appropriate for the condition.

Exclusions	Examples
Household and Personal Items	• Household items including but not limited to – Air cleaners and/or humidifiers – Bathing apparatus – Scales or calorie counters – Blood pressure kits – Water beds • Personal and convenience items including but not limited to – Foam cushions – Pajamas – Nonmedical, nonapproved expenses for personal services or comfort including, but not limited to, charges for legal counsel, nonmedical transportation, hotel accommodations, meals, telephone charges, and reimbursement for time off from work • Cosmetics • Homemaker services • In-hospital personal items, including but not limited to – Guest trays – TV rental – Telephone
Illness or injury caused by a third party's wrongful act or negligence	Payment of Plan benefits is subject to the Plan's right to reimbursement/subrogation.
Infertility Treatment	• Any costs associated with the collection, preparation, or storage of sperm or eggs, including donor fees • Reversal of voluntary sterilization
Military Expenses	Care for military service-connected disabilities for which the covered participant is legally entitled to services and for which facilities are reasonably available to the covered member
Miscellaneous	• Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder • Care for conditions that state or local law requires to be treated in a public facility or court-ordered services not ordered by a licensed provider and approved by the respective health plan's Medical Director or designee • Charges in excess of "allowable charges" (see definition in Appendix A, Acronyms and Definitions) • Claims received after one year from the date the charges were incurred

Exclusions	Examples
	• Counseling for activities of an educational nature • Counseling related to consciousness raising • Counseling for borderline intellectual functioning • Dietary supplements and nutritional formulas • Expenses incurred while not covered by this Plan • Eye refraction measurements, eyeglasses, corrective lenses, other eye appliances, eye exercises, the fitting of eyeglasses, or the surgical treatment for the correction of a refractive error (with the exception of contact lenses used for the medically necessary treatment of keratoconus) • Hearing aids, ear molds, and the fitting of hearing aids and ear molds • IQ testing • Long-term rehabilitative therapy • Membership costs or fees associated with health clubs and weight loss clinics • Nonskilled nursing home care • Orthodics • Penile implants, unless medically necessary • Prayer, spiritual healing, or religious counseling • Private-duty nursing unless determined to be medically necessary by the respective health plan's Medical Director or designee • Psychological testing on children requested by or for a school system, unless medically necessary • Repairs for durable medical equipment and prosthetic or orthotic devices that are owned by the covered member • Routine physical exams, checkups, and inoculations required for licensing, employment, marriage, insurance • Treatment for injuries sustained by a covered member in the course of committing a felony if the covered member is subsequently convicted of the felony • Treatment of developmental disorders • Treatment of organic mental disorders associated with permanent dysfunction of the brain
Not Medically Necessary	• Services not generally recognized as medically necessary, such as – Behavioral training – Hair analysis – Sex change procedures not part of medically necessary

Exclusions	Examples
	correction of congenital defects
Obesity	All medical and surgical services for the treatment or control of obesity not considered medically necessary
Organ transplant	• The medical and hospital services for transplants not meeting the criteria on page 37 as a covered benefit • Fees associated with the collection or donation of body organs
Transportation	Ambulance services not medically necessary
Work-Related Injury or Illness	Work-related injuries and illnesses **Note:** If you suffer an injury or illness that you believe is work-related, you should contact your Sandia Medical Organization for instructions. Should your injury or illness prove not to be work-related, the Plan will cover services only if care has been obtained in accordance with requirements described in this SPD.

Accessing Care

This section outlines selecting a primary care physician (PCP), the Plan identification (ID) cards, and provider networks under the Plan. You will also find out how to access care under the in-network and out-of-network options for nonemergency and nonurgent care as well as for emergency and urgently needed care for medical and for behavioral health conditions. Benefits available under the Employee Assistance Program are also discussed. In addition, if you have been denied medical services or have a complaint regarding the quality of care you received, this section provides you with information on the Quality of Care grievance procedures as well as appeals procedures for the denial or limitation of services.

Selecting a Primary Care Physician

As a covered member, you must select a participating PCP, even if you do not intend to use the in-network benefit. A PCP is a family practice physician, a general practice physician, an internist or a pediatrician. Pregnant members can select their obstetrician to be their PCP during pregnancy. You and your covered dependents can select the same PCP or you can select a different PCP for each person.

If you do not select a PCP during your enrollment, CIGNA will select one for you and notify you by mail. Please call a Member Services Representative at 800-CIGNA24 or 800-244-6224 to assist you in selecting a PCP who best meets your needs.

Tip

To change your PCP, contact a CIGNA Member Services Representative at 800-CIGNA24 or 800-244-6224. The change will be effective the first day of the following month.

Identification (ID) Cards

Upon enrollment, you will be issued an ID card (for each covered member). If additional cards are needed, please contact Member Services at 800-CIGNA24 or 800-244-6224.

Always carry your ID card with you. Call Member Services immediately if your ID card is lost or stolen.

The ID card shows some of the benefits you and your dependents are entitled to and the required copayments.

Provider Networks

CIGNA strives to make available to you quality health care services by way of CIGNA's provider credentialing processes. The networks are either contracted with or owned by CIGNA and even though Sandia strives to provide you with quality medical services, neither Sandia nor its plans can guarantee quality of care. These providers have no contract with Sandia National Laboratories. Members always have the choice of what services they receive and who provides their healthcare regardless of what the plan covers or pays. CIGNA maintains a broad network of providers within the service areas covered under this Plan.

In the Greater Albuquerque area, the providers, specialty care physicians, hospitals, and other health care providers/facilities participating in the network are affiliated with Lovelace or the University of New Mexico. CIGNA has also established direct contracts with other providers in the community. The participating providers work with CIGNA to organize an effective and efficient health care delivery system.

Medical Specialty Networks

CIGNA is committed to providing access to quality health care through today's innovative and technologically advanced medical options. As a CIGNA member, you have access to the CIGNA LIFESOURCE Organ Transplant Network, a network of participating organ transplant centers. Developed by a team of CIGNA HealthCare Medical Directors, this Network includes respected hospitals and medical centers throughout the United States.

As part of the credentialing program, each transplant facility is evaluated for favorable rates of patient outcomes, as well as waiting period, housing arrangements, and "patient friendly" environments, before it is included in the Network.

As a CIGNA member, you can have access to these services when they are coordinated through your PCP and your CIGNA HealthCare Plan Medical Director. Members receiving services under this Network and who are required to travel to a transplant facility approved by CIGNA will receive an allowance for travel and related expenses. Some of these expenses that are reimbursed are considered taxable income. Expenses most likely giving rise to taxable income

include (1) reimbursement of amounts in excess of $0.30 per mile for use of a personal car, (2) reimbursement of expenses for meals, and (3) reimbursement of expenses in excess of $50 per night for lodging. CIGNA will provide a Form 1099 to any member who has received taxable reimbursements during the prior calendar year. The member is responsible for reporting such taxable reimbursement to the IRS when filing his or her annual return.

Provider Directories

Provider directories can be requested at no charge from:

- The Sandia Benefits Department at 845-2363 in New Mexico or 294-2254 in California
- CIGNA Member Services at 800-CIGNA24 or 800-244-6224, or
- The Web at www.CIGNA.com

Example: To access a physician through the Web

- Log on to www.CIGNA.com.
- Click on "Consumers."
- Go to "Select a popular link."
- Scroll down to "Provider Directory."
- Select "Physicians" under CIGNA HealthCare.
- Select "Managed Care Plans with Primary Care Physicians," enter a zip code or state, and indicate whether you are looking for a primary care or specialty physician.
- The Web site will walk you through the rest.

Although CIGNA makes its best effort to keep this online directory updated, there is no guarantee that a physician listed in this directory is still a network provider. It is recommended that you call CIGNA Member Services at 800-CIGNA24 or 800-244-6224 for the most current participating provider information.

IMPORTANT **If you go to a provider that is not a network provider and you have no referral to that provider from CIGNA, you will not receive in-network benefits.**

In Network

When you enroll in this Plan, you and your covered dependents select a primary care physician (PCP) from the CIGNA network of providers. Your PCP will

provide various health services and will arrange for laboratory tests, x-rays, referrals to specialists, hospitalization, or any other service that may be necessary.

Each time you have a health problem, call or make an appointment with your PCP. Please have your ID card available when you call. If you need a same-day appointment or have an urgent illness, call your PCP's office to see if there are open appointment times. You may be offered an appointment with another physician, nurse practitioner, or physician assistant. If it is after hours, contact your PCP's office first. If you are unable to get assistance from your PCP's office, call 800-CIGNA24 or 800-244-6224 and select the Health Information Line.

When you arrive for your appointment, show your ID card to the receptionist to receive in-network benefits. If a copayment is required, you must pay it at the time of service. If you are unable to keep an appointment, cancel as soon as possible.

Regardless of the decision and/or recommendation for referrals, procedures, surgeries, hospitalizations, etc., or what the Plan will pay, it is always up to the member and the doctor to decide what, if any, care he/she receives.

If your PCP determines that you need the services of another physician, hospital, health care professional, or special facility, your PCP will submit a referral. Referrals are processed through your respective health plan. All diagnostic tests must have a referral from a participating provider to receive in-network benefits. To receive in-network benefits, **do not** obtain the service until you are sure that the referral has been approved. If you wish to inquire about the status of a referral, please call a Member Services Representative at 800-CIGNA24 or 800-244-6224.

NOTES: Female members may self-refer to a participating OB/GYN for gynecological conditions and their annual well-woman exam and receive in-network benefits.

This Plan will not pay for nonapproved services obtained from a participating provider at the in-network benefit level except in medical emergencies. **See Emergency/Urgent Care, p. 51.**

If hospitalization is necessary, your participating provider will discuss this with you and assist in making arrangements. Except for an emergency, hospitalizations must have prior authorization from your respective health plan's

Medical Director or designee. You may contact CIGNA Member Services at 800-CIGNA24 or 800-244-6224 to verify prior authorizations for hospitalizations. In cases of an emergency, you must notify CIGNA within 48 hours following your admission.

You may obtain a second surgical opinion by contacting your PCP for the appropriate referral. If the first and second opinion disagree and you chose to take the opinion that the surgery is needed, the health plan will require documentation of medical necessity. If you would like a third opinion, you must submit a request for review to your respective health plan as these are not always covered.

A covered member may, for personal reasons, decline treatment recommended by participating providers. Participating providers may regard such declinations as incompatible with the continuance of the physician-patient relationship and as obstructing the provision of proper medical care. If a covered member declines such recommended treatment and the providers believe that no professional acceptable alternative exists, neither CIGNA nor any participating providers will have further responsibility to care for the condition or any complications as long as a covered member continues to decline the treatment.

Out of Network

Out-of-network coverage allows you to self-refer to any licensed provider or facility within or outside of the CIGNA network. When you receive care, show your ID card for proof of coverage. You must pay for services rendered and file a claim for reimbursement. See Plan Benefits, page 25, and Filing Your Claims, page 69.

Preadmission certification is required for hospitalizations, and your stay will be subject to continued stay review. You are responsible for obtaining preadmission certification and if you do not obtain preadmission certification,

- You will be subject to a $500 penalty (i.e., reduction in benefit reimbursement) in addition to the deductible, and
- You may also be subject to the denial of benefits if the services are determined not to be medically necessary. If, after preadmission certification and/or continued stay review, you are informed that your hospital stay does not meet the requirements for hospitalization and/or continued hospitalization and you are admitted into and/or remain in the hospital, you will not be reimbursed for expenses incurred.

For any type of invasive testing, for durable medical equipment, or for external prosthetic purchases or rentals or for the following surgeries, it is recommended that you obtain prior approval for medical necessity to ensure benefit coverage:

- Acetabuloplasty, plastic or reconstructive operation of the hip (anthoplasty of the hip)
- Cataract surgery, eye surgery
- Cholecystectomy, removal of the gall bladder
- Coronary bypass, surgery of the coronary artery
- Dilation and curettage
- Excision of cyst or other breast tissue
- Hallux valgus procedures, surgery of the big toe to correct deformity, including bunionectomy
- Hemorrhoidectomy, removal of hemorrhoids
- Herniotomy, hernia repair
- Hysterectomy, removal of the uterus
- Laminectomy/spinal fusion, surgery of the spine
- Meniscectomy, removal of torn cartilage of the knee
- Ostectomy or osteotomy of the foot, bone surgery of the foot
- Patellectomy or hemipatellectomy, removal of all or part of the kneecap
- Prostatectomy, removal of all or part of the prostate
- Septoplasty, surgical reconstruction of the nose, including submucous resection
- Tenosynovectomy, surgery of tendon sheath (wrist only)
- Tonsillectomy and/or adenoidectomy, removal of tonsils or adenoids
- Varicose vein surgery

IMPORTANT **Not all services are eligible to receive out-of-network benefits. Refer to Services Not Covered Under the Out-of-Network Benefit, page 27, to see what services are not covered on an out-of-network basis.**

IMPORTANT **Regardless of the decision and/or recommendation for referrals, procedures, surgeries, hospitalizations, etc., or what the Plan will pay, it is always up to the member and the doctor to decide what, if any, care he/she receives.**

Case Management

Case management is a program that, as early as possible, identifies patients who have the potential for having high-cost medical expenses, may require extensive

hospitalization, or have complicated discharge planning needs. The intent of case management is to ensure that medically necessary and appropriate services are provided. The evaluation process used may reduce medically unnecessary, inappropriate, and/or harmful services, and manage costs in some cases. Identification of potential case management patients is driven by the patient's diagnosis. Special care arrangements, as determined by the case manager, are coordinated with the primary care physician and may include benefits for services that are not ordinarily covered.

Case management is a voluntary, confidential, and private process and may involve some or all of the following activities:

- Establishing goals and a care plan with the physician, member, and/or family that may include on-site visits
- Assessing ongoing treatment at a hospital, rehabilitation center, nursing home, hospice, or member's home
- Investigating alternative facilities and services
- Establishing home health care treatment, if appropriate
- Planning for discharges

Emergency/Urgent Care

Emergency care and urgently needed care coverage through this Plan are very specific, **so please read this section carefully.** Be sure you know what steps to take when a nonoccupational medical emergency arises. Coverage is available worldwide for emergency and urgent care at in-network benefit levels if it meets the criteria as outlined in these sections.

Definition and Examples of Medical Emergency

A medical emergency is an accidental injury or the sudden and unexpected onset of a condition requiring immediate medical or surgical care. Certain conditions are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Other conditions are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or the sudden inability to breathe. There are many other acute conditions that CIGNA may determine are medical emergencies. Any of these emergencies require quick action.

Reimbursement for emergency care will not be denied if, in good faith and with average knowledge of health and medicine, you seek emergency care for an illness that you believe is an acute condition that requires immediate medical

attention. CIGNA will take the following factors into consideration in determining if the illness or condition is reimbursable as emergency care:

- A reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or next available appointment,
- The time of day the care was provided,
- The presenting symptoms, and
- Any circumstances that prevented the member from seeking emergency care under established Plan guidelines.

Emergencies Occurring Within the Service Area

If you have an emergency, go to the nearest hospital emergency room. These facilities are open 24 hours a day, seven days a week.

If you need to be hospitalized, you or your family members or designated representative must notify CIGNA within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify CIGNA within that time. If you are hospitalized in nonparticipating facilities and participating providers believe care can be better provided in a participating hospital, you will be transferred when medically feasible with any ambulance charges covered in full. If you decline to be transferred, coverage will be provided under the out-of-network benefit. For information about ambulance services, see Plan Coverages and Limitations, page 28.

If you have received emergency medical care from a nonparticipating provider, follow the procedures outlined under Filing Your Claims, page 69.

Emergencies Occurring Outside the Service Area

If you have an emergency, go to the nearest hospital emergency room. These facilities are open 24 hours a day, seven days a week.

The Plan will pay at the in-network benefit level for treatment of sudden, unexpected, and acute illnesses or injuries you receive from out-of-area providers in the case of a medical emergency. Expenses for health care services you should have received before leaving the service area that could have been postponed safely until your return may be eligible for coverage at the out-of-network benefit level. See Emergency Services Not Covered In Network, page 53, for more information.

If you need to be hospitalized, you or your family members or designated representative must notify CIGNA within 48 hours or on the first working day following your admission, unless it is not reasonably possible to notify CIGNA within that time. If you are hospitalized in nonparticipating facilities and participating providers believe care can be better provided in a participating hospital, you will be transferred when medically feasible with any ambulance charges covered in full. If you decline to be transferred, coverage will be provided under the out-of-network benefit. For information about ambulance services, see Plan Coverages and Limitations, page 28.

If you have received emergency medical care from a nonparticipating provider, follow the procedures outlined under Filing Your Claims, page 69.

Emergency Benefits Covered In Network

Coverage at the **in-network** benefit level includes the following:

- Emergency care at a doctor's office;
- Emergency care at an urgent care center;
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services; and
- Ambulance service if approved by the Plan.

IMPORTANT **If you are treated for an emergency by a nonparticipating provider, in order to be covered at the in-network benefit level, this Plan requires that you submit all bills to CIGNA within 120 days after the date of service (see Completing Claim Forms, page 69).**

Emergency Services Not Covered In Network

The following services are **not** covered:

- Elective, nonemergency care, including follow-up care;
- Emergency care provided outside the service area if the need could have been foreseen before departing the service area;
- Supplies, medications, and durable medical equipment provided outside the service area if the need for them could have been foreseen before departing the service area;
- Care received after it is medically feasible to return to the service area.

NOTE: Coverage for these services may be available at the out-of-network benefit level. This Plan requires that all bills for out-of-network services be submitted to CIGNA within one year of the service date.

Tip

When Planning a trip, please call a Member Services Representative at 800-CIGNA24 or 800-244-6224. A recommendation of medical providers located in your destination area may be available.

Definition and Examples of Urgent Care

The 24-hour Health Information Line is a health information service staffed by registered nurses who provide callers with health and referral information. **See page 91.**

Urgent care is defined as care provided for medical events that are not life-threatening but require prompt medical attention. Examples of urgent situations include sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, colds, fevers, small lacerations, minor burns, severe stomach pains, swollen glands, rashes, poison ivy, and back pain.

Urgently Needed Care Occurring Inside the Service Area

When an urgent illness or injury occurs, call your PCP's office. Your PCP or the physician on call will direct you to the appropriate facility to receive care. You will be responsible for the copayment at the time of service. If you receive care

- In a participating physician's office, the copayment will be $10;
- In a participating urgent care facility, the copayment will be $25;
- In a participating emergency room, the copayment will be $50.

If you go to a **nonparticipating** physician, urgent care facility, or emergency room, you must pay for services rendered and file a claim for reimbursement. The claim may be subject to review for in-network benefits for the appropriateness of using a nonparticipating physician or facility. For example, if you live in Albuquerque and have an urgent situation that could be handled by a Lovelace urgent care facility but you go to a Presbyterian urgent care facility, and time is not a critical factor, most likely the claim will be denied under the in-network benefit. The claim would be processed subject to out-of-network benefits. See Filing Your Claims page 69, and Plan Benefits, page 25.

Urgently Needed Care Occurring Outside the Service Area

Go to the nearest appropriate provider/facility for care. You must pay for services rendered and submit a claim for reimbursement. See Filing Your Claims, page 69.

If you receive care

- In a physician's office, you will be reimbursed down to the $10 copayment;
- In an urgent care facility, you will be reimbursed down to the $25 copayment;
- In an emergency room, you will be reimbursed down to the $50 copayment.

Behavioral Health Services

To access in-network nonurgent or urgent behavioral health services, call CIGNA Behavioral Health at 800-333-5415, 24 hours a day, seven days a week. In the event of an emergency, go to the nearest hospital emergency room. If you are admitted to an inpatient facility or to a partial hospitalization program, you must notify CIGNA within 48 hours. For outpatient behavioral health care, your initial visit is at no charge, whether it qualifies under the Employee Assistance Program (EAP) benefit or not. (See Employee Assistance Program, below, for information on EAP benefits.) If it qualifies under the EAP, you will be eligible to receive services under the EAP. If it does not qualify under the EAP, you will be eligible to receive the benefits as outlined under the outpatient mental health/substance abuse rehabilitation benefit (see Plan Benefits, page 25).

Employee Assistance Program

Sandia offers counseling services of an Employee Assistance Program (EAP). The EAP counseling services are designed to provide assessment, referral, and follow-up to employees experiencing some impairment from personal concerns including, but not limited to: health, marital, family, financial, substance abuse, legal, emotional, stress, or other personal concerns that may adversely affect day-to-day activity.

Eligibility

Services through CIGNA Behavioral Health providers are available to employees, retirees, and their dependents **who are enrolled in this Plan**.

NOTE: Retirees and their dependents are not eligible to receive on-site services under the EAP.

Accessing EAP Services

You are offered two access points to receive EAP counseling:

- You may obtain **on-site** EAP counseling by contacting your Sandia EAP office at 845-8085 in New Mexico and 294-2200 in California,

- You may obtain **off-site** EAP counseling by calling 800-333-5415 toll free, 24 hours a day, and informing them that you would like to make an appointment under the EAP benefit through Sandia.

The EAP benefit is not available under the out-of-network option.

EAP Benefits and Preauthorization Requirements

Your EAP benefit allows up to eight visits annually to the SNL EAP service staff or to a CIGNA Behavioral Health provider **at no cost to you**. However, if, in the initial screening visit, it is determined that the treatment needed is beyond the scope of the EAP, the member will be referred to the appropriate Plan services for treatment. These subsequent services will be provided under the applicable Plan benefit, and the member will be required to pay the applicable charges. See Plan Benefits, page 25.

If the initial screening visit confirms that the problem can be handled through the EAP, the CIGNA Behavioral Health provider (if applicable) will arrange for the appropriate authorization.

No claims filing is required for on-site or off-site EAP services.

Each member is eligible to receive up to eight visits per calendar year if different problems are being addressed by separate family members. For example, a member and his/her spouse cannot be covered for more than eight visits for marital issues.

Coordination Between Sandia and CIGNA

The Sandia on-site EAP counselors and CIGNA may need to work in conjunction with each other to provide the most effective treatment for the member. If an employee, or his or her covered dependent, accesses an on-site EAP counselor and the on-site EAP counselor determines that a CIGNA provider is the most appropriate individual to treat the member, the on-site EAP counselor will make a referral to the CIGNA provider. If the treatment is still deemed EAP-related, there will be no charge to the member for the subsequent visits up to the maximum allowed under the EAP. If the treatment is deemed otherwise, the member will be subject to the terms and provisions of the plan governing the benefit provided. Refer to Plan Benefits, page 25.

On-Site EAP Services

The Sandia on-site EAP provides information, education, and training programs at the work site that focus on mental health issues such as substance abuse, family and marital concerns, stress, and healthful lifestyle development. For further information, call 845-8085 in New Mexico and 294-2200 in California.

Confidentiality

EAP counseling services are confidential within the limitations imposed by state and federal law and regulations. When a member visits an EAP counselor for the first time, confidentiality is described in more detail.

Grievance Process for Quality of Care/Service Concerns

Members of the Plan have the right to file a concern/grievance regarding quality of care/service issues. This process is outlined below. A quality of care concern/grievance relates to the medical care you received from a provider, while a quality of service concern/grievance relates to such things as parking, the attitude of the office staff, etc.

Filing a Concern

Contact CIGNA Member Services at 800-CIGNA24 (800-244-6224) to file a concern regarding the quality of care or quality of service.

For quality of care concerns, the information is forwarded to the Quality of Care Peer Review Committee for follow-up. You will receive written notification when the case has been closed but because of confidentiality between CIGNA and its providers, you will not receive the outcome or recommendation of the Quality of Care Peer Review Committee.

Upon receipt of a quality of service concern, the Member Services Representative will attempt to resolve your concern. If the Member Services Representative is unable to resolve your quality of service concern in the initial call, the Member Services Representative will advise you of how he/she will continue to work on the concern. If the Member Services Representative is unable to resolve your quality of service concern to your satisfaction within five business days, you will receive a letter advising you of your appeal rights.

Level I Grievance Appeal

This level of appeal is used when you or your representative request an appeal of a quality of service concern you filed because you were not satisfied with the resolution provided by the Member Services Representative. You can request this appeal either orally or in writing.

The Grievance Coordinator will send you a written acknowledgment/response within five business days of receipt of your request for a Level I grievance appeal. The Grievance Coordinator will forward the appeal to the appropriate department for resolution within 30 business days of the initial complaint. Once a decision has been made, you will receive a letter informing you of the outcome.

Level II Grievance Appeal

If you are not satisfied with the resolution provided by the Level I Grievance Appeals process, you may request a Level II Formal Grievance Appeal Hearing before the Grievance Appeals Hearing Committee. This request may be either oral or in writing to the Grievance Coordinator.

The Grievance Coordinator will send you written notification within five business days of receipt of your request. You have the right to

- Participate in the meeting either in person or by telephone
- Present any additional information you feel would assist the Committee in making its determination, and
- Bring legal counsel, if you desire.

The Grievance Appeals Hearing Committee consists of the following voting members who were not involved in any previous determinations:

- The Chairperson, who is the Manager of the Appeals Division of Member Services, or his or her designee,
- A Medical Director, or his or her designee,
- A representative from the Member Services Department, and
- A representative of the Sales Department.

You will be given 20 minutes to present your position and provide additional information. Following your presentation and questions and answers, you will be dismissed from the hearing.

The Appeals Specialist will notify you in writing within five business days of the recommendation of the Committee.

Appeals Procedures for Denial or Limitation of Services

This section outlines the appeals procedures available to you in situations where the Utilization Management review process has resulted in a denial or limitation of medical services **before** you have obtained the services. Some examples include denial of a referral to a specialist, denial of physical therapy, etc. Utilization Management review is the process used to review whether health care services are medically necessary and the most beneficial to your care. You must exhaust the appeal procedures before bringing legal action.

Regardless of the decision and/or recommendation for referrals, procedures, surgeries, hospitalizations, etc., or what the Plan will pay, it is always up to the member and the doctor to decide what, if any, care he/she receives.

CIGNA has 20 days, or 30 days if an extension is requested, to complete both appeal levels (if applicable) from the time of receipt of your original request for appeal. In situations where the standard appeal process could jeopardize your life or health or your ability to regain maximum function, you, your designated representative, or your provider can request an "expedited" review. This expedited review at both the Level I and Level II appeals processes must be completed within 72 hours of the initial appeal request.

NOTE: For appeals procedures for claim denials, see Filing an Appeal, page 72.

Level I Appeal

Upon receipt of a phone call or letter from you, your designated representative, or your provider to CIGNA Member Services, the Member Services Representative will submit your appeal request with any accompanying documentation to the Appeals Division of Member Services.

The respective health plan's Medical Director or a designee who is not involved in the original adverse determination will review your request and, if necessary, discuss your case with your provider. The Medical Director or designee can

- Reverse the denial or limitation based on new information supplied by your provider, or

- Uphold the denial or limitation, or
- Suggest an alternative or modification to the previously denied or limited treatment plan based on the new information or further discussions with the involved provider(s).

In the case of an expedited review where the Medical Director or the designee upholds the original adverse determination, your case will automatically be routed to the Level II appeal process unless you specifically state that you do not want to pursue this matter further.

Level II Appeal

If you are not satisfied with the decision of the Medical Director or the designee, you can request that your case be heard before a medical panel review committee of at least two physicians and/or other health care professionals who have not been previously involved in the determination at issue.

You have the right to

- Attend the hearing,
- Present your case to the panel,
- Submit appropriate material before or at the hearing, and
- Be assisted or represented by a person of your choice.

Upon request, CIGNA will provide you with a list of board-certified specialty consultants who practice in the same specialty as would typically manage a case of this nature. You may also designate a specialist to participate in the review at your own expense.

You must exhaust the appeal process before you request an external review or seek any legal recourse.

External Independent Review Process

If you are not fully satisfied with the decision following completion of the Level II appeal process and your appeal was denied based upon lack of medical necessity or the experimental nature of the treatment and the services will exceed $1,000, you may request that your appeal be reviewed by an external independent review organization. The independent review organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. There is no charge for you to initiate this independent review process. CIGNA HealthCare will abide by the decision of the independent review.

NOTE: Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the CIGNA HealthCare Appeals Coordinator within 180 days of your receipt of the Level II appeal review denial. You will be provided with additional information on the external review process at that time and be asked to provide any new information relative to your appeal. The Appeals Coordinator will then forward the file to the independent review organization. The independent review organization will render an opinion within 30 days upon receipt of all information. The decision of the independent review organization is binding upon CIGNA HealthCare. If you are not satisfied with the outcome of this review, you have the right to seek legal recourse.

The Claims Administrator has the exclusive right to interpret the provisions of the CIGNA Network POS Plan, to construe its terms, and to determine the benefits thereunder. The determination of the Claims Administrator is conclusive and binding.

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Guest Privileges Program

The Guest Privileges Program allows covered members to enroll as "guests" at another CIGNA HealthPlan site if they temporarily relocate to another geographical area of the United States for a period of 90 days or longer. The CIGNA HealthPlan network is national and is likely to have a HealthPlan at your new location. The CIGNA HealthPlan must have an approved guest site in the relocation area in order for you to enroll in the Guest Privileges Program. Routine and preventive care are included in this program.

Who Is Eligible

The Guest Privileges Program is a way to arrange for health care coverage in situations such as

- Temporary job transfers or assignments to another division or subsidiary;
- Family separations because of divorce;
- Relocation (when a part of the family does not move until the end of the school year);
- Children attending school away from home.

NOTE: Temporary job transfers or extended relocation are generally limited to a maximum of two years.

EXCEPTION

Dependent children can be covered at the CIGNA HealthPlan guest site until their eligibility ends.

How To Enroll

Call a CIGNA Member Services Representative at 800-CIGNA24 (800-244-6224) to request information about guest privileges. A kit will be mailed to you that will contain all the information necessary for enrolling at the guest site. The enrollment process takes about 30 to 60 days. Once the process has been completed, the guest has full access to the guest plan's network and is treated in every way like a "regular" member at that site. Guests covered by this Plan contract will receive their home Plan benefits with the closest guest site copayment available.

The program is generally recommended for a dependent who needs primary medical care while away at school. You should talk with a Member Services Representative regarding the advisability of enrolling a "well" dependent student in the program. The health plans generally do not transfer the person back to the home health plan for summer vacations, and never for shorter-term vacations. If the dependent has a good relationship with his/her PCP at the home site and prefers to continue that relationship for routine examinations and ongoing care, enrollment in the Guest Privileges Program may not be advisable.

Guest members should realize that they will only have urgent and emergency care as well as out-of-network benefits available at home if they use guest privileges for coverage while away at school.

For more information about guest privileges, or for help completing the enrollment form, call a CIGNA Member Services Representative at 800-CIGNA24 (800-244-6224).

NOTE: If you want home-site routine health care from your participating provider instead of transferring all care to a guest site, you may not want to participate in the Guest Privileges Program because that would only allow emergency or urgent care when you are at home.

Coordination of Benefits

This section defines and explains the Plan provisions designed to eliminate duplicate payments and provide the sequence in which coverage will apply (primary and secondary) when a person is covered under two plans.

Policy

All benefits under this Plan are subject to coordination with the benefits of other health care plans including Medicare if they are considered covered expenses under this Plan. Covered expense means any expense that is covered by at least one plan during a claim period; however, any expense that is not payable by the primary plan because of the member's failure to comply with cost containment requirements (e.g., second surgical opinions, preadmission testing, preadmission review of hospital confinement, mandatory outpatient surgery, etc.) will not be considered a covered expense and therefore is not paid under this Plan.

Coordination of Benefits Rules

All benefits under this Plan are subject to coordination with the benefits of other health care plans. See Appendix A, Acronyms and Definitions, for "coordination of benefits" and "primary plan."

The rules for the coordination of benefits (COB)

- Apply only to group plans, **not** to individual insurance.
- Do **not** apply when married persons are both employed by Sandia.
- Follow the birthday rule.

Rules for Determining Which Plan is Primary and Other Details of the Benefit Payment Plan

Use the following table to determine

- Whether your plan is primary and
- Which plan pays the benefit for employees, spouses, and dependents.

If . . .	then . . .
the other plans (including HMOs) does not have a COB provision,	the plan with no COB provision is primary.
both plans have COB provisions,	the plan covering the person as an employee is primary and will pay benefits up to the limits of that plan. The plan covering the person as a dependent is secondary and pays the remaining costs to the extent of coverage.
both plans have COB provisions and use the birthday rule for dependent children coverage,	the plan covering the parent whose birthday comes first (month and day) in the year is the primary plan and will pay benefits first. The plan covering the other parent is secondary and pays the remaining costs to the extent of coverage.
both plans have COB but neither plan uses the birthday rule for dependent children's coverage,	the male-female rule applies. The father's group insurance is the primary plan and will pay the benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.
both plans have COB but one parent is covered by the male-female rule and the other by the birthday rule,	the male-female rule applies. The father's group insurance is the primary plan and will pay the benefits first. The mother's group insurance is secondary and pays the remaining costs to the extent of her coverage.

If . . .	then . . .
the divorce or legal decree establishes financial responsibility for health care for the covered dependent children,	the parent who has that responsibility will be the holder of the primary plan.
a divorce decree does not establish financial responsibility and assigns joint custody,	each parent is primary when the child is living in his or her home
the divorce decree does not establish financial responsibility for health care of the covered dependent children,	the plan of the parent with custody is the primary plan. The other parent's plan is secondary.
the divorce decree does not establish financial responsibility, and the parent with custody remarries,	the custodial parent's plan remains primary; the stepparent's plan is secondary. The noncustodial parent's plan is third.
payment responsibilities are still undetermined,	the plan that has covered the patient for the longest time is the primary plan.

Subrogation Rights

Subrogation means Sandia's right to recover any Plan payments made because of an illness or injury to you or your covered dependent caused by a third party's wrongful act or negligence and for which you or your covered dependent have a right of action or later recovered payments from the third party.

If you or your covered dependent requires medical treatment because of a third party's wrongful act or negligence, CIGNA will authorize payment of Plan benefits, pursuant to the terms of the Plan. As a Plan participant, you and your covered dependents acknowledge and agree to the following:

- The Plan is subrogated to any recovery from or right of action against that third party (agree to pay Sandia back if third party pays you),
- You and/or your covered dependent will not take any action that would prejudice the Plan's subrogation rights (will not impede Sandia's recovery actions), and
- You and/or your covered dependent will cooperate in doing what is reasonably necessary to assist in any recovery including seeking recovery of medical expenses as an element of damages in any action you bring as a result of the activity resulting in the illness or injury (will assist Sandia directly or indirectly to recover payments).
- You and/or your covered dependent shall reimburse CIGNA from any money recovered from the third party for any injury or treatment or condition for which the Claim Administrator provided benefit; and

- CIGNA will recover payments only to the extent that Plan benefits for treatment were provided as a result of the injury or condition giving rise to the claim.

Sandia will be subrogated only to the extent of Plan benefits paid for that injury.

NOTE: If the injured party is a minor dependent, the primary member must perform the above agreements/duties.

Failure to comply with the Plan's subrogation rules may result in termination of coverage for cause (see page 77), as well as legal action by the Plan to recover benefits paid that would otherwise have been subject to recovery under the Plan's reimbursement/subrogation rights.

Filing Your Claims

This section outlines how to obtain and complete claim forms and how to file for reimbursement. It covers benefits payments and the appeals procedure and outlines the Claim Administrator's right to recover excess payments

Obtaining Claim Forms

For most in-network benefits, you will not need to file a claim.

If you receive services under the out-of-network benefit or have received emergency or urgent medical care from a nonparticipating provider, you will need to obtain an Out-of-Network Claim Form. This form is available from the Sandia BCSC at 845-BENE (2363), the Web under Corporate Forms (SF4400-00N), or CIGNA Member Services at 800-CIGNA24 or 800-244-6224. If the emergency or urgent medical care you received from a nonparticipating provider is deemed eligible under the in-network benefits, you will be reimbursed down to the applicable copayment.

Tip

Canceled checks, cash receipts, or "balance due" statements are NOT acceptable in lieu of original bills and may cause delay in reimbursement.

Completing Claim Forms

Follow the instructions on the Out-of-Network Claim Form and send it, along with itemized bills, to the address shown on the member ID card. When completing the claim form, include

- Your full name and Social Security number and
- The patient's full name, date of birth, and relationship to you.

Itemized bills must include the

- Date and place of treatment,
- Diagnosis,
- Type of service rendered,
- Amount charged,
- Complete name and address of the licensed provider, and
- Tax identification number of the licensed provider.

Tip

Questions regarding claims may be directed to CIGNA Member Services at 800-CIGNA24 or (800-244-6224).

If another insurance is primary, send their Explanation of Benefits (EOB) with the itemized bill.

When services are related to an accident, be sure you or your physician include a full description of how, where, and when the accident occurred and when you began treatment for it. See Subrogation Rights, page 67.

Filing Claims

Mail claims to CIGNA at:

CIGNA HealthCare
P.O. Box 182223
Chattanooga, TN 37422

Allow four weeks for claims processing and for receiving reimbursement and/or an EOB.

IMPORTANT

1. **This Plan requires that you submit any out-of-network claim to CIGNA within one year after the medical expenses are incurred.**
2. **This Plan requires that you submit any claims for emergency or urgent care at a nonparticipating provider to CIGNA within 120 days after the medical expenses are incurred in order to receive in-network benefit reimbursement.**

Benefits Payments

Tip

You will NOT receive an EOB for in-network services unless the service is not covered, the copayment has not been paid, or the claim is pending for more information. You will always receive an EOB for out-of-network services incurred.

Plan benefits are paid to the primary covered member on behalf of the covered member as soon as possible after receipt of written proof of claim. You should wait four weeks before initiating an inquiry on your claim.

NOTE: The person who received the service is responsible for settling the amount payable with the provider.

Benefits for the following charges may be paid directly to the provider of the services if the covered member has so directed on the claim form:

- Hospital,
- Nursing,
- Medical,
- Surgical, and
- Other medical expenses.

If any benefits of the plan shall be payable to the estate of a participant or to a minor or individual who is incompetent to give a valid release, the plan may pay

such benefits to any relative or other person either whom the plan determines to have accepted competent responsibility for the care of such individual or otherwise required by law. Any payment made by the plan in good faith pursuant to this provision shall fully discharge the plan and the company to the extent of such payment.

Nonassignment of benefits—The participant cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the plan before receipt of that benefit. Interest in the plan is not subject to the claims of creditors.

Exceptions:

- Qualified Medical Child Support Order that requires a health plan to provide benefits to participant's child.
- Subject to written direction of a participant, all/portion of benefits provided by the plan may, at option of plan and unless individual requests otherwise in writing, be paid directly to the person rendering such service. Any payments made by the plan in good faith pursuant to this provision shall fully discharge the plan and the company to the extent of such payment.

Written Notice of Claim Denial by CIGNA

The Claim Administrator has the exclusive right to interpret and apply the provisions of this Plan and to construe its terms with the exception of eligibility. Sandia has the exclusive right to determine eligibility (with the exception that CIGNA determines eligibility of a dependent due to a physical or mental impairment). Plan provisions require that a member pursue all claim and appeal rights as described below before seeking any other legal recourse regarding claims for benefits. The determination of the Claim Administrator is conclusive and binding.

If you have a claim denied because of …	Then…
Coverage eligibility	Contact the Sandia BCSC, 505-8445-BENE (2363) Refer to Eligibility Appeals Procedures, page 13
Benefits administration or any other reason	Contact CIGNA at 800-CIGNA24 (244-6224)

If a claim for some or all of the benefits is denied, CIGNA will provide the covered member with

- A description of services denied and
- A written notice of the specific reason(s) not covered.

Filing an Appeal

You, your dependent, or other duly authorized person may appeal this denial or action in writing **within 180 days** after your receipt of notification of CIGNA's decision if a claim for benefits is denied in full or in part.

The appeal should be sent to

CIGNA HealthCare
P.O. Box 182223
Chattanooga, TN 37422

Level 1 Appeal

Upon receipt of written notification from you, your dependent, or duly authorized person to CIGNA HealthCare at the above address, your appeal request will be submitted with any accompanying documentation to the Appeals Division of Members Services.

The respective health plan's Medical Director or designee who was not involved in the original adverse determination will review your request and, if necessary, discuss your case with your provider. The Medical Director or designee can

- Reverse the denial or limitation based on new information supplied by your provider, or
- Uphold the denial or limitation, or
- Suggest an alternative or modification to the previously denied or limited treatment plan based on the new information or further discussions with the involved provider(s).

Level II Appeal

If you are not satisfied with the decision of the Medical Director or designee, you can request that your case be heard before a medical panel review committee of at least two physicians and/or other health care professionals who have not been previously involved in the determination at issue.

You have the right to

- Attend the hearing,
- Present your case to the panel,
- Submit appropriate material before at the hearing, and

- Be assisted or represented by a person of your choice.

Upon request CIGNA will provide you with a list of board-certified specialty consultants who practice in the same specialty as would typically manage a case of this nature. You may also designate a specialist to participate in the review at your own expense.

Regardless of the decision and/or recommendation for referrals, procedures, surgeries, hospitalizations, etc., or what the Plan will pay, it is always up to the member and the doctor to decide what, if any, care he/she receives.

CIGNA has 20 days, or 30 days if an extension is requested, to complete both appeal levels (if applicable) from the time of receipt of your original request for appeal.

External Independent Review Process

If you are not fully satisfied with the decision following completion of the Level II appeal process and your appeal was denied based upon lack of medical necessity or the experimental nature of the treatment, and if your claim was above $1,000, you may request that your claim be reviewed by an external independent review organization. The independent review organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. There is no charge for you to initiate this independent review process. CIGNA HealthCare will abide by the decision of the independent review.

NOTE: Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the CIGNA HealthCare Appeals Coordinator within 180 days of your receipt of the Level II appeal review denial. You will be provided with additional information on the external review process at that time and be asked to provide any new information relative to your appeal. The Appeals Coordinator will then forward the file to the independent review organization. The independent review organization will render an opinion within 30 days upon receipt of all information. The decision of the independent review organization is binding upon CIGNA HealthCare. If you are not satisfied with the outcome of this review, you have the right to seek legal recourse.

The Claims Administrator has the exclusive right to interpret the provisions of the CIGNA Network POS Plan, to construe its terms, and to determine the

benefits thereunder. The determination of the Claims Administrator is conclusive and binding.

Recovery of Excess Payment

The Claim Administrator has the right at any time to recover any amount paid by this Plan for covered charges in excess of the amount that should have been paid under Plan provisions. Payments may be recovered from covered members, providers of service, and other medical care plans.

By accepting benefits under this Plan, the covered member agrees to reimburse payments made in error and cooperate in the recovery of excess payments.

When Coverage Stops

This section contains the general rules covering when benefits under this Plan stop for employees (active and retired) and dependents. See Continuation and Conversions, page 79, for specific rules governing when health care coverage stops and how it may be continued for

- Surviving spouses,
- Covered persons on leave of absence,
- Long-term disability (LTD) beneficiaries, and
- Covered members paying for coverage under temporary continued coverage.

Tip

Health care coverage may be continued in some situations. Refer to Continuation and Conversions, page 79, for COBRA rules. Also, special rules apply to leaves of absence for family medical care and military service. See the Family and Medical Leave Act section of the *Sandia Employee Benefits Binder* and pages 22 and 81 of this SPD.

Employees (Active or Retired)

Plan benefits for active and retired employees stop on the

- Last day of the month the employee is no longer eligible (e.g., leave of absence or termination of employment), **except** as provided under temporary continuation of coverage under COBRA. See Continuation and Conversions, page 79.
- The later of the day of the move or the date Sandia Benefits receives notification from an employee or retiree who changes his or her residence to beyond the service area, provided the disenrollment form is received by the BCSC within 31 calendar days of the change in residence.

  NOTE: You have the option to obtain coverage under another Sandia-sponsored medical plan, provided you notify the Sandia BCSC within 31 calendar days of your change in residence.

- Date the Plan is terminated.
- Last day of the month in which any cost of the coverage is not paid when due.
- Date of death.
- Last day of the month before the month in which the retiree becomes eligible for Medicare primary coverage.

If a member is eligible for Medicare primary coverage and resides in the Lovelace Senior Plan Service Area, the member will be enrolled in the Lovelace Senior Plan.

NOTE: The LSP is available only in certain ZIP codes in New Mexico. If you live in a ZIP code area that is not covered under the LSP, you and your covered dependents will have to disenroll from this Plan and enroll in another Sandia-sponsored medical plan to continue coverage through Sandia.

IMPORTANT **You must provide Sandia Benefits with a copy of your Medicare card showing you have both Medicare Parts A and B by the first of the month prior to the month in which you will be eligible for Medicare primary coverage.**

Dependents

Plan benefits for dependents stop on the

- Date a dependent child becomes eligible for coverage as an employee under any medical plan offered by Sandia,
- Last day of the month in which any cost of coverage for dependents is not paid when due,
- Date employee's or retiree's coverage stops,*
- Last day of the month in which the dependent spouse legally divorces or separates from the employee/retiree,*
- Last day of the month in which a dependent child marries or ceases to be eligible under the definition of dependent,* or
- Last day of the month in which an employee or retiree terminates dependent coverage.

IMPORTANT **If you are paying dependent premiums on an after-tax basis, refer to page 20 for the rules regarding dependent disenrollment. If you are paying dependent premiums on a pre-tax basis, also refer to the Pre-Tax Premium Plan Booklet for the rules regarding dependent disenrollment.**

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* In this event, the dependent may be eligible for temporary continued coverage under COBRA. See Continuation and Conversions, page 79.

Termination by CIGNA for Cause

CIGNA may terminate a member's coverage for cause, upon 30 days written notice, or with written notice effective immediately for gross misconduct. Cause for termination of a member's coverage may include any of the following:

- Failure to pay copayments,
- Permitting an unauthorized person to use your ID card (unless you notified CIGNA that your card was lost or stolen),
- Repeated failure to make or keep appointments for medical care,
- Declination of Plan benefits,
- Abuse of Plan coverage by providing false information on applications or forms,
- Failure to follow Plan provisions,
- Verbal or physical threats to a CIGNA employee, physician, or a CIGNA provider,
- Fraudulent receipt of Plan services for noncovered persons, or
- Failure to comply with subrogation/reimbursement provisions.

Covered members terminated for cause are not eligible for any COBRA continuation or individual conversion.

Certificate of Group Health Plan Coverage

When the Sandia BCSC learns of your loss of medical coverage, or the loss of coverage for your dependents, you will receive a Certificate of Group Health Plan Coverage, which provides proof of your prior health care coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six-month period before you enrolled in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy an insurance policy for yourself or your family that does not exclude coverage for medical conditions that are present before you enroll.

If you do not receive a Certificate of Group Health Plan Coverage, you can obtain one by calling the Sandia BCSC within 24 months of the loss of coverage.

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Continuation and Conversions

This section outlines how coverage can be continued for you and/or your covered dependents in the event that you retire, take a leave of absence, become disabled, terminate your employment, or die.

If, for any reason, you stop active full-time or part-time work, contact Sandia Benefits to determine what arrangements, if any, may be available for continued coverage under this Plan. In some cases, there are special provisions for members to continue coverage. Also, Sandia abides by a federal law referred to as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1987 in which temporary continued coverage is made available to primary participants and their covered dependents who would otherwise lose group coverage because of specific events.

Subject to stated qualifications and requirements, coverage may be continued

- During retirement,
- During leaves of absence (LOA),
- During disability,
- For surviving spouse and dependents,* and
- For eligible persons under temporary continued coverage (COBRA).

* Surviving spouses and dependents covered under this Plan at the time of death of the employee or retiree will continue coverage under this Plan for the first six months following the employee or retiree's death. Provided that a timely election is made (within the first six months) coverage will be continued under the selected medical plan. (Refer to Coverage for Surviving Spouse and Dependents, page 83, for more information.)

The CIGNA Network POS Plan is maintained at the discretion of Sandia and is not intended to create a contract of employment and does not change the at-will employment relationship between you and Sandia. The Sandia Board of Directors (or designated representative) reserves the right to suspend, change, or amend any or all provisions of the CIGNA Network POS Plan, and to terminate the CIGNA Network POS Plan at any time without prior notice, subject to applicable collective bargaining agreements. If the CIGNA Network POS Plan should be terminated or changed, it will not affect your right to any benefits to which you have already become entitled.

Tip

When retirees or their eligible dependents become eligible for Medicare primary, their benefits are provided through the LSP if enrollment is done in a timely manner and they live within the service area in New Mexico. If a retiree or his/her eligible dependent becomes eligible for Medicare primary benefits, but not eligible for the LSP, the retiree and dependent must disenroll and enroll in another medical plan.

IMPORTANT

1. Covered members (and their covered dependents) who voluntarily terminate Plan coverage while still employed with Sandia, or who were terminated for cause by CIGNA, or who were terminated from Sandia for gross misconduct, are not eligible for any COBRA continuation or individual conversion.

2. In the absence of an eligible mid-year election event or waiver of coverage due to other group health coverage, any covered members who terminate their membership are not eligible to re-enroll in a Sandia-sponsored medical plan until the next Open Enrollment period held each fall. (Refer to When Coverage Stops, page 75, and Eligibility, page 7, for more information.)

3. If a covered person is eligible for Medicare primary, the converted policy for which you are eligible will be limited to membership in the Lovelace Senior Plan (LSP) if you live within the LSP service area.

During Retirement

If you retired before January 1, 1995, Sandia pays the full cost of coverage for you and your covered dependents during retirement if you retired

- Between January 1, 1988, and December 31, 1994, with a service or disability pension;

- Before January 1, 1988, with at least 15 years of service;* or
- Between August 8, 1977, and January 1, 1988, at age 65 or older with at least 10 years of service as of age 65.**

Retirees who retired with a service or disability pension after December 31, 1994, will share in the cost of coverage in this Plan. Call the BCSC at 505-845-2363 for costs of coverage.

If you retire from Sandia but do not meet any of the above conditions, you may continue coverage under COBRA by paying the full cost of coverage. Refer to page 85.

NOTE: The LSP is available only in certain ZIP codes in New Mexico. If you live in a ZIP code area that is not covered under the LSP, you and your covered dependents will have to disenroll from the Plan and enroll in another Sandia-sponsored medical plan to continue coverage through Sandia.

IMPORTANT **You must provide Sandia Benefits with a copy of your Medicare card showing you have both Medicare Parts A and B by the first of the month prior to the month in which you will be eligible for Medicare primary coverage.**

During Leaves of Absence

LOA for child care and family care—Sandia pays the employer portion of the premium for the Plan for the first six months. For active employees, see detailed information in your *Sandia Employee Benefits Binder* under Family Medical Leave Act. Employees who remain on LOA beyond six months must pay the full cost of coverage to continue their medical benefits.

LOA to the military—Sandia pays the employer portion of the premium for the Plan for the first six months. Employees who remain on LOA beyond six months must pay the full cost of coverage to continue their medical benefits.

All other LOAs—Coverage stops at the end of the month in which the LOA begins. Coverage may be continued by paying the full premium for the length of the LOA.

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* If you retired with a service or disability pension before August 8, 1977, with less than 15 years of service pay service, you pay one-half the cost of coverage.

** If you retired between August 8, 1977, and January 1, 1988, with less than 15 years of service and are younger than 65 and have a service or disability pension, you pay one-half the cost of coverage.

If you continue coverage under a Leave of Absence, this time counts toward temporary continued coverage under COBRA.

Employees on an LOA are not charged the 2% COBRA administration fee.

Contact the Sandia BCSC at 845-BENE (2363) if you have questions.

During Disability

Employees disabled after January 1, 1982, and before retirement (disability terminees) who are eligible to receive benefits from the Sandia Long-Term Disability (LTD) Plan will have coverage continued until the end of the month in which the

- LTD recipient recovers and benefits cease,
- LTD benefits cease for any reason, or
- LTD recipient dies.

Sandia will pay the majority of costs for the POS Plan; however, you must pay a monthly premium share. Contact the BCSC for information.

Covered LTD participants eligible for Medicare primary coverage must enroll in Medicare Parts A and B to continue coverage through Sandia. If you reside within the service area for LSP, coverage will be provided under the Lovelace Senior Plan. If you do not reside within the LSP service area, you must disenroll and enroll in another Sandia-sponsored medical plan. As soon as you become eligible for Medicare primary coverage, you need to contact the Benefits Department.

NOTE: The LSP is available only in certain ZIP codes in New Mexico. If you live in a ZIP code area that is not covered under the LSP, you and your covered dependents will have to disenroll from the Plan and enroll in another Sandia-sponsored medical plan to continue coverage through Sandia.

You must provide Sandia Benefits with a copy of your Medicare card showing you have both Medicare Parts A and B by the first of the month prior to the month in which you will be eligible for Medicare primary coverage.

Coverage for the Surviving Spouse and Dependents

The following table contains the terms of coverage for the surviving spouse and dependents at the time of death of on-roll regular employees and most retired employees.

NOTE: When a survivor or dependent child is or becomes Medicare primary during the first six months after the employee's/retiree's death, coverage under the Plan will terminate, and the survivor or dependent child will be enrolled in the LSP for the remainder of the six months. Any remaining dependents who are non-Medicare primary will remain on the CIGNA POS Plan for the remainder of the six months.

The LSP is available only in certain ZIP codes in New Mexico. If you live in a ZIP code area that is not covered under the LSP, you and your covered dependents will have to disenroll from the Plan and enroll another Sandia-sponsored medical plan whichever is applicable, to continue coverage through Sandia.

You must provide Sandia Benefits with a copy of your Medicare card showing you have both Medicare Parts A and B by the first of the month prior to the month in which you will be eligible for Medicare primary coverage.

Coverage	Surviving Spouse and Dependents	Dependent Children with No Surviving Parent
First six months	Employer portion paid for by Sandia	Employer portion paid for by Sandia
	EXCEPTION **The first six months of coverage for survivors of those retired employees paying their own premiums at the time of death are NOT paid for by Sandia.**	
Continued coverage	May continue coverage for life at the full cost of coverage if elected in the first six months after employee's/retiree's death.	Option to purchase up to an additional 30 months of coverage can be obtained through COBRA.

Special Rules

- All Class I dependents covered at the time of death of the employee or retiree are eligible.
- No new dependents can be added **unless** a qualifying COBRA event occurs within the first 36 months after the member's death. (Temporary continued coverage is explained under COBRA, page 85.)
- The first six months of coverage and any continued coverage for surviving spouses and dependents count toward the temporary continued coverages explained under COBRA, page 85.

Termination Rules

For the surviving spouse and covered dependents, coverage terminates if

- A spouse remarries. (If remarriage occurs less than 36 months after the employee's/retiree's death, the spouse and covered dependents may have rights under COBRA, [see page 85].)
- Payments are not received when due.
- A surviving spouse dies (if less than 36 months after the employee/retiree death, covered dependents may have rights under COBRA [see below]).

COBRA

A federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) became effective January 1, 1987. This law requires Sandia to offer a temporary extension of health care coverage to primary covered members and dependents who would otherwise lose their group health coverage as a result of certain events (see Events Causing Loss of Coverage, page 86).

The cost of coverage is at the applicable group rate plus a 2% administrative fee.

NOTE: If you lost Plan coverage because of termination of employment and you are or become disabled and you are not eligible for long-term disability benefits or a service or disability pension, you will be charged 150% of the applicable group rate after the first 18 months. See page 86.

Qualified beneficiaries under COBRA include

- You (the employee),
- Your spouse, or
- Your dependent children

if covered under this Plan the day before the events causing loss of coverage.

In addition, a qualified beneficiary under COBRA also includes a child born to or placed for adoption with a covered employee during the period of the employee's or retiree's continuation coverage. Newborn children or adopted children need to be enrolled in the Plan within 31 calendar days from their date of birth, adoption, or placement for adoption, whichever is applicable. Once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan rules, the child will be treated like all other COBRA qualified beneficiaries.

If you have another group plan on the date of your qualifying COBRA event, you may still be eligible for COBRA. However, the other group health plan would provide your primary coverage; this plan would provide only secondary coverage.

Covered persons terminated for cause by CIGNA or by Sandia for gross misconduct are not eligible for any COBRA continuation or individual conversion.

If a COBRA participant moves out of the network service area, the participant will be offered another applicable medical plan offered by Sandia.

Events Causing Loss of Coverage

These are the specific events causing loss of coverage for terminees, surviving spouses, and dependents. The length of time for the optional COBRA coverage is noted.

If you are the . . .	and if you, the covered person, lose POS Plan coverage because of . . .	then, under COBRA, you have the right to choose temporary continued coverage for a maximum of. . .
employee, spouse or a dependent child	■ a reduction in the number of hours of employment at Sandia ■ termination of employment, including retirement	18 months.
employee, spouse, or a dependent child	■ termination of employment, and you are disabled or become disabled within the first 60 days of your COBRA coverage as determined by Social Security and you do not have Medicare coverage*	29 months. **Note:** After the first 18 months, you will be charged 150% of the cost of the regular premium.
spouse	■ the death of the Sandia spouse **Note:** See page 83 for the surviving spouse option. ■ a divorce or legal separation from your Sandia spouse	36 months.

* You must notify the Sandia BCSC at 845-BENE (2363) within 60 days of the date Social Security determines that you or a family member is disabled and within the first 18 months of COBRA continuation of coverage.

If you are the . . .	and if you, the covered person, lose POS Plan coverage because of . . .	then, under COBRA, you have the right to choose temporary continued coverage for a maximum of. . .
dependent	■ the death of a Sandia parent **Note:** See page 83 for the surviving dependent option. ■ a divorce or legal separation of your parents ■ a change in eligible status, (i.e., dependent ceases to be a dependent child under the Plan, such as stepchildren of divorced parents, eligible dependent of a surviving spouse who dies, or a child who turns 24)	36 months.

IMPORTANT **Additional events, such as death, divorce, legal separation, or Medicare entitlement, that occur during the initial 18-month period or during disability extension may extend the COBRA period to 29 or 36 months for qualified beneficiaries, but in no event will coverage extend beyond 29 or 36 months after the initial qualifying event. Sandia must be notified of the second qualifying event within 60 days in order to be eligible for the extension.**

Notification and Election of COBRA

The following table shows notification and election actions for temporary continued coverage under COBRA.

Step	Who	Action
1	Employee or family member	Notify Sandia BCSC in writing at P.O. Box 5800, Albuquerque, NM 87185-1022 within 60 days* of ■ divorce, ■ legal separation, ■ loss of a child's dependent status, ■ disability designation by Social Security, ■ death of a primary covered participant other than an employee.
2	BCSC	Notify Sandia COBRA administrator of covered participant's ■ death, ■ termination of employment, or ■ loss of eligibility.
3	Sandia COBRA Admin-istrator	Notify participants that they have the right to choose continued coverage within 60 days from latest of the following dates: ■ notification by Sandia BCSC, ■ coverage actually ends.
4	Covered participant	Contact the COBRA Administrator at Sandia to elect COBRA coverage. ■ Covered participant has 60 days to elect COBRA from the latter of the date of the notice or their loss of coverage date, whichever is later. ■ Covered participant has 45 days from the election date to make first premium payment and a 30-day grace period every month thereafter. ■ **If you elect continued coverage**, then Sandia provides coverage under the Plan **at your expense** plus the applicable administrative fee. **Note:** See Coverage for Surviving Spouses and Dependents, page 83. ■ **If you do not elect continued coverage,** then group coverage under the Plan ends.

* If you fail to inform the Sandia BCSC within 60 days of the notification date, you will no longer be eligible to participate in COBRA.

The following benefits apply to COBRA participants:

- A Qualified Beneficiary (QB) is entitled to the same coverage as he/she had before the mid-year change event.
- They have the same open enrollment period rights as similarly situated active employees.
- If coverage is modified for similarly situated active employees, the coverage to COBRA beneficiaries is modified in the same manner.
- If the employer discontinues the plan or benefit package under which the Qualified Beneficiaries were receiving benefits, they must still be able to receive different employer-provided coverage.
- Qualified Beneficiaries receiving COBRA coverage have the right to enroll family members under HIPAA special enrollment rules as active employees and plan participants.
- If a COBRA participant moves out of the service area, they will have the same coverage available to other insureds living out of the service area.

Termination of Temporary Coverage

Temporary continued coverage under the Plan may be terminated prior to 18, 29, or 36 months when

- Sandia no longer provides coverage to any employee.
- The premium for continued coverage is not paid within the grace period.
- The covered member becomes covered under any other type of group health plan. If that group plan has an exclusion or limitation regarding preexisting conditions, you can continue to purchase temporary continued coverage to obtain coverage for your preexisting condition. However, the other group health plan would provide your primary coverage; this Plan would provide only secondary coverage.
- The covered participant is eligible and enrolls for Medicare coverage (i.e., Medicare is primary).
- A fraudulent claim is submitted.

Coverage extensions required under other laws (e.g., state law) or provided by other provisions of this Plan, such as Leaves of Absence, or for surviving spouses, continue concurrently with (i.e., count toward) temporary continued coverage, available under COBRA.

Conversion Privileges

If you have been covered under this Plan for at least three months and coverage ends for any reason other than voluntary termination of coverage, nonpayment of premiums, termination of coverage by CIGNA for cause, or termination from Sandia for gross misconduct, **then** you may apply to CIGNA for individual coverage under a converted policy without submitting evidence of good health.

This conversion coverage does not provide the same benefits as those provided by the CIGNA Network POS Plan.

Rules for Applying for Conversion

The rules for applying for conversion are as follows:

- The form and terms of the converted policy are determined by CIGNA at the time you apply for conversion.
- You must apply to CIGNA within 31 calendar days after coverage under the Plan terminates.
- You must pay for the cost of coverage.
- The converted policy becomes effective on the day after coverage under the Plan terminates.
- If issuing a converted policy results in over-insurance or duplication of benefits, CIGNA may refuse to issue a converted policy.

CIGNA Administrative Services

Member Services

Member Services representatives are available to assist you with the following:

- PCP selection and change
- Enrollment information
- Questions about covered services
- Prevention and wellness programs, classes, and information
- Procedures for obtaining care
- Information about referral status
- Status of claims payment
- Complaints or concerns
- Appeals and grievance procedures

If you have a question or concern, please call the Member Services Department at 800-CIGNA24 (800-244-6224) between 8 AM and 5 PM (MST), Monday through Friday. You can also access eligibility, benefits, and claims through the Web at www.cigna.com.

24-Hour Health Information Line

The Health Information Line is a health information service staffed by registered nurses who provide callers with health and referral information. The nurses answer health-related questions and help callers determine the seriousness and urgency of their medical symptoms. The system can also be linked directly to 911 in cases of emergencies and is equipped with devices to communicate with deaf or hearing-impaired individuals. This service also serves as a resource and referral service for health and community services. You may call the Health Information Line free of charge 24 hours a day, seven days a week at 800-CIGNA24 or 800-244-6224.

CIGNA's Healthy Rewards Program

The Healthy Rewards Program provides discounts for services such as massage therapy, laser vision correction, hearing aids, and for products such as vitamins and herbal supplements so every member can benefit from these complements to traditional medicine. Call 800-870-3470 or access www.cigna.com to find out more information about this program.

NOTE: The Healthy Rewards Program is separate from the medical benefits provided under this Plan.

Appendix A

Acronyms and Definitions

Acronyms

BCSC	Benefits Customer Service Center
COB	coordination of benefits (see definition)
COBRA	Consolidated Omnibus Budget Reconciliation Act
EAP	Employee Assistance Program
EBC	Employee Benefits Committee
EOB	Explanation of Benefits
ERISA	Employee Retirement Income and Security Act
FMLA	Family and Medical Leave Act
GIFT	gamete intrafallopian transfer
HIPAA	Health Insurance Portability and Accountability Act
ID	identification
IQ	intelligence quotient
IRS	Internal Revenue Service
LOA	leave of absence
LSP	Lovelace Senior Plan
LTD Plan	Long-Term Disability Plan
OB/GYN	obstetrical/gynecological

PAC	pre-admission certification (see definition)
PCP	primary care physician (see definition)
POS	point-of-service
PTPP	Pre-Tax Premium Plan (see definition)
QMCSO	Qualified Medical Child Support Order (see definition)
RSA	Reimbursement Spending Accounts (see Health Care Reimbursement Spending Account)
SPD	Summary Plan Description
TMJ	temporomandibular joint
U&C	usual and customary (see definition)
ZIFT	zygote intrafallopian transfer

Definitions

allowable charges

Usual and customary (U&C) charges if the provider has a contract with CIGNA, or the contracted fee

alternate payee/recipient

A child or custodial parent who is not a primary covered participant and who, because of a "qualified medical child support order" (see definition), is entitled to receive reimbursement directly from CIGNA

behavioral health

Mental health and/or substance abuse

child(ren)

Children include:

- The primary covered participant's own children and legally adopted children.
- Adopted child (if the placement agreement and/or final adoption papers have been completed and submitted to your Sandia BCSC).
- Stepchildren living with the primary covered member (stepchildren visiting for the summer are not considered to be living with you).
  Note: Refer to definition for "living with you."
- Child for whom you have legal guardianship.
- Natural child, legally adopted child, or child for whom you have legal guardianship **if** a court decree requires you to provide coverage.

See Eligible Dependents, page 11, for an explanation of children to be covered by the POS Plan.

Claim Administrator

The third party designated by Sandia to receive, process, and pay claims according to the provisions of the POS Plan

Class II dependent	Includes your unmarried child who is not eligible as a Class I dependent, unmarried grandchild, unmarried brother or sister, or unmarried parent or grandparent or spouse's parent or grandparent who is financially dependent on you, has a total income from all sources of less than $15,000 per year other than the support you provide and has lived in your home or one provided by you in the United States for the most recent six months. **Class II dependents are eligible for coverage only under the Two Option Medical Plan, TOP PPO, Intermediate PPO, and Basic PPO.**
COBRA	Requires Sandia to offer a temporary extension of health care coverage to primary covered members and dependents who would otherwise lose their group health coverage as a result of certain events
coinsurance	Cost-sharing feature by which the POS Plan pays a percentage of the covered charge, and the covered member pays the balance of that covered charge
coordination of benefits	When a covered participant has medical coverage under other group health plans (including Medicare), POS Plan benefits are reduced so that total combined payments from all plans do not exceed 100% of the highest allowed U&C charges or the lowest negotiated fee
copayment/copay	Cost-sharing feature by which the POS Plan pays the remainder of the covered charge after the covered member pays his or her portion as a defined dollar amount.
covered member	An eligible employee, retiree, surviving spouse, or COBRA covered person who has coverage under the POS Plan and his or her dependents who have coverage under the POS Plan. See also "primary covered member."

custodial care

Services or supplies, regardless of where or by whom they are provided, that

a. A person without medical skills or background could provide or could be trained to provide; or

b. Are provided mainly to help the insured person with daily living activities, including (but not limited to)

- Walking, getting in and/or out of bed, exercising and moving the insured person;
- Bathing, using the toilet, administering enemas, dressing and assisting with any other physical or oral hygiene needs;
- Assistance with eating by utensil, tube, or gastrostomy;
- Homemaking, such as preparation of meals or special diets, and house cleaning;
- Acting as a companion or sitter; or
- Supervising the administration of medications that can usually be self-administered, including reminders of when to take such medications; or

c. Provide a protective environment; or

d. Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve the insured person's sickness, injury, or functional ability; or

e. Are provided for the convenience of the insured person or the care giver or are provided because the insured person's own home arrangements are not appropriate or adequate.

deductible

Covered charges incurred during a calendar year that the covered member must pay in full before the POS Plan reimburses the covered member for additional covered charges

dual Sandians

Both spouses are employed by or retired from Sandia

EAP counselor

A licensed master's or Ph.D.-level mental health clinician who provides information, assessment, short-term counseling, and referrals

emergency

See medical emergency

experimental/ investigative

Any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical practice in the state in which services are provided. In addition, if federal or other governmental agency approval is required for use of any items and such approval was not granted at the time services were administered, the service is experimental. To be considered standard medical practice and not experimental or investigative, treatment must meet all five of the following criteria:

- A technology must have final approval from the appropriate regulatory government bodies,
- The scientific evidence as published in peer-reviewed literature must permit conclusions concerning the effect of the technology on health outcomes,
- The technology must improve the net health outcome,
- The technology must be as beneficial as any established alternatives, and
- The improvement must be attainable outside the investigational settings.

financially dependent persons

Persons who receive greater than 50% of their financial support from the primary covered member

follow-up care

Re-examination of or maintenance of contact with a patient at prescribed intervals following diagnosis or treatment

Health Care Reimbursement Spending Account

Pre-tax money that is set aside to be used to help pay for health care expenses not reimbursed or only partially reimbursed by any medical, dental, vision plan, or other health insurance plan. This account can be used by active employees only.

health maintenance organization

An affiliation of health care providers offering health care to enrollees

hospice

A program provided by a licensed facility or agency that provides home health care, homemaker services, emotional support services, and other service provided to a terminally ill person whose life expectancy is six months or less as certified by the person's physician.

hospital

The term "hospital" means:

- An institution licensed as a hospital, that
  a) Maintains, on the premises, all facilities necessary for medical and surgical treatment;
  b) Provides such treatment on an inpatient basis, for compensation, under the supervision of physicians; and
  c) Provides 24-hour service by registered graduate nurses;
- An institution that qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals; or
- An institution that
  a) Specializes in treatment of mental illness, alcohol or drug abuse, or other related illness;
  b) Provides residential treatment programs; and
  c) Is licensed in accordance with the laws of the appropriate legally authorized agency.

The term "hospital" will not include an institution that is primarily a place for rest, a place for the aged, or a nursing home.

Leave of Absence

An approved absence without pay for more than 30 consecutive calendar days. See CPR300.6.18 for more information.

living with you

A person living in your home at least 50% of the year or living in a home provided by you. Stepchildren visiting for the summer are **not** considered to be living with you.

Medical Director

The physician designated by the health plan with review/consultation responsibilities for medically related functions such as quality assurance programs, utilization review of care, and appeals of denied claims

medical emergency

A sudden and unforeseeable sickness or injury of such a nature that failure to get immediate medical care could be life threatening or cause serious harm to bodily functions, as determined by the respective health plan's Medical Director or designee

medically necessary

Services or supplies provided by a hospital, physician, or other provider that the medical director or designee has determined are

- Consistent with symptoms, diagnosis, treatment, and not experimental or investigative;
- Appropriate in keeping with standards of good medical practice;
- Not solely for the convenience of the member, plan physicians, or other health care plan provider;
- Appropriate level of service that can be safely provided to the member;
- In accordance with accepted standards of medical practice, could not have been omitted.

The fact that a physician may provide, prescribe, order, recommend, or approve a service or supply does not in itself make the service or supply medically necessary or make the charge for it allowable even though the service or supply is not specifically listed as an exclusion in the POS Plan.

Medicare primary

Medicare pays benefits first; Sandia's plan second

Medicare

A federal program administered by the Social Security Administration that provides benefits partially covering the cost of necessary medical care

member

See covered member

nonparticipating

Licensed provider or facility **not** contracted with or employed by CIGNA

Open Enrollment period

The period of time every year when you have the option to change your medical coverage for the subsequent calendar year (normally held in the fall of each year)

out-of-pocket maximum

The covered member's financial responsibility for covered medical expenses **before** the Plan reimburses additional covered charges at 100%, with no deductible, for the remaining portion of that calendar year

outpatient surgery facility	A facility that is either free-standing or associated with a hospital or physician's office that is permanently equipped to perform surgery without requiring an overnight stay
partial hospitalization	Provided for the patient to go home at night to sleep and return to the hospital during the day in order to participate in the hospital programs provided
participating	Licensed provider or facility contracted with or employed by CIGNA
physician	See "provider"
Plan	CIGNA Network POS Plan
Plan administrator	Sandia National Laboratories
post-secondary educational program	Students who are classified as Graduate, Professional, Administrative or Co-op; Graduate Engineering Minorities; Undergraduate Co-op, General Clerical, Technical or Business; and General Laborer.
preadmission certification	The process used to certify the medical necessity and length of any hospital confinement
Pre-Tax Premium Plan	A Plan that allows employees to pay premiums on a pre-tax basis
primary care physician	The physician who coordinates and manages your total health care from routine physicals to hospitalizations, ensuring that you receive the most appropriate care for your medical needs. Your PCP may practice in Family Practice, Pediatrics, or Internal Medicine and may provide referrals to participating specialty care physicians, hospitals, and other health care providers.
primary covered member	The person for whom the coverage is issued, that is, the Sandia employee, retiree, survivor, or the individual who is purchasing temporary continued coverage
primary Plan	The Plan that has the legal obligation to pay first when more than one health care plan is involved
prior approval	See "prior authorization"

prior authorization	The process of obtaining prior approval from the respective health plan's Medical Director or designee for a service or medication
provider	■ A physician or surgeon licensed to prescribe and administer drugs, provide treatment for a medical condition, or perform surgery ■ A duly licensed medical practitioner operating within the scope of his or her license overseen by a board of the healing arts ■ A licensed facility operating within the scope of its license
qualified beneficiary	An employee, spouse, or dependent covered the day before the qualifying event, to include a child who is born to or placed for adoption with the covered employee during COBRA. Qualified beneficiaries must be given the same rights as similarly situated employees/beneficiaries.
qualified medical child support order	A judgment, decree, order, or property settlement agreement issued either by a court of competent jurisdiction or through an administrative process established under state law which has the force and effect of law in that state in connection with State domestic relation law that either (1) creates or extends the rights of an "alternate payee/recipient" (see definition) to receive the reimbursement from the Plan or (2) enforces certain laws relating to medical child support.
qualifying event	Under COBRA, an event that but for the COBRA requirements would result in the loss of coverage to a qualified beneficiary
referral	Recommendation by a participating provider for a member to receive health care from another participating provider
Sandia-sponsored medical Plans	Two Option Medical Plan, Top PPO, Intermediate PPO, Basic PPO, CIGNA POS Plan, Lovelace Senior Plan, Kaiser HMO, Kaiser Senior Advantage Plan, St. Joseph's Medicare Plus Plan
service area	The geographical area, approved by the appropriate staff agency, within which participating providers are accessible to members

short-term counseling

For Sandia's EAP, one to eight problem assessment/counseling visits per member per calendar year. Individuals or dependents/families may access the visits separately if different problems are addressed.

skilled nursing care facility

An institution or that part of an institution that provides convalescent or nursing care and is, or could be, certified as a skilled nursing care facility under Medicare.

specialist

A physician who provides specialty services

subrogation

The Plan's or Claim Administrator's right to recover any POS Plan payments made because of sickness or injury to you or your dependent caused by a third party's wrongful act or for negligence and for which you or your dependent have a right of action or later recovered said payments from the third party

substance abuse

Abuse by the individual of drugs, alcohol, or other chemicals to the point of addiction, which has been diagnosed as an illness by a licensed physician

total disability or totally disabled

Because of an injury or sickness

1. You are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit; or
2. Your dependent is
   (a) Either physically or mentally unable to perform all of the usual duties and activities (the "normal activities" of a person of the same age and gender who is in good health); and
   (b) Not engaged in any work or occupation for wages or profit.

Two Option Medical Plan

A preferred provider medical plan that includes an in-network option, and an out-of-network option; the medical plan available to Sandia employees represented by the Metal Trades Council and the Office and Professional Employees International Union and formerly represented retirees who retired prior to January 1, 2002

urgent care	Care provided for medical events that are not life-threatening but require prompt medical attention. Examples of urgent situations include sprains, strains, vomiting, cramps, diarrhea, bumps, bruises, colds, fevers, small lacerations, minor burns, severe stomach pains, swollen glands, rashes, poison ivy, and back pain.
urgent care facility	Can be attached to a hospital or be free-standing, staffed by licensed physicians and nurses, and providing health care services
urgent care services	Treatment of a sudden or severe onset of illness or injury
usual and customary charges	The amount determined by the Claim Administrator based on the range of fees charged by physicians for the same or similar service within the locality. The Claim Administrator has the exclusive right to determine the usual and customary (U&C) amount. The POS Plan allows for payment up to, but not over, the U&C charges.
utilization management/ review	A process used to review whether health care services are medically necessary and the most beneficial to your care

Appendix B

Member Rights and Responsibilities

CIGNA is committed to providing high-quality health care that is cost effective for all members. You have certain rights and assume certain responsibilities as you enter into a partnership with CIGNA. It is important that you fully understand both your rights and your responsibilities.

You Have the Right To:

- Medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
- Get the information you need about your health care plan, including information about services that are covered, services that are not covered, and any costs that you will be responsible for paying.
- Have access to a current list of providers in the CIGNA HealthCare network and have access to information about a particular provider's education, training and practice.
- Select a Primary Care Physician (PCP) for yourself and each covered member of your family, and to change your PCP for any reason, as often as three times a year.
- Have your medical information kept confidential by CIGNA HealthCare employees and your health care provider. Confidentiality laws and professional rules of behavior allow CIGNA HealthCare to release medical information only when it is required for your care, required by law, necessary for the administration of your plan or to support CIGNA HealthCare programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify you or any other participants specifically.
- Have your health care provider give you information about your medical condition and your treatment options regardless of benefit coverage or cost. You have the right to receive this information in terms you understand.
- Learn about any care you receive. You should be asked for your consent for all care, unless there is an emergency and your life and health are in serious danger.
- Refuse medical care. If you refuse medical care, your health care provider should tell you what might happen. We urge you to discuss your concerns about care with your PCP. Your doctor will give you advice, but you will always have the final decision.

- Be heard. Our complaint-handling process is designed to hear and act on your complaint or concern about CIGNA HealthCare and/or the quality of care you receive, provide a courteous, prompt response, and to guide you through our grievance process if you do not agree with our decision.

You Have the Responsibility To:

- Review and understand the information we send you about your health care plan. Please call CIGNA HealthCare Member Services when you have questions or concerns.
- Understand how to use CIGNA HealthCare services.
- Show your CIGNA HealthCare ID card before you receive care.
- Schedule a new patient appointment with any new CIGNA HealthCare Primary Care Physician (PCP), build a comfortable relationship with your doctor, ask questions about things you don't understand, and follow your doctor's advice. You should also understand that your condition may not improve and may even get worse if you don't follow your doctor's advice.
- Provide honest, complete information to the providers caring for you.
- Know what medicine you take, and how to take it.
- Pay all copayments for which you are responsible, at the time service is received.
- Keep scheduled appointments and notify the doctor's office ahead of time if you are going to be late or miss an appointment.
- Pay all charges for missed appointments and for services that are not covered by your plan.
- Voice your opinions, concerns or complaints to CIGNA HealthCare Member Services and/or your provider.